NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

PREAMBLE

1. Sections Affected	**Rulemaking Action**
R9-22-712.20	Amend
R9-22-712.25	Amend
R9-22-712.30	Amend
R9-22-712.35	Amend
R9-22-712.40	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

Implementing statute: A.R.S. § 36-2903.01(H)

3. The effective date of the rules:

The rules are effective October 1, 2011, which is more than 60 days after the filing of the rules with the Secretary of State. The Administration determined that good cause exists for and the public interest will not be harmed by the later effective date, as required by A.R.S. §41-1032(B).

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

Notice of Rulemaking Docket Opening: 17 A.A.R. 269, February 18, 2011

Notice of Proposed Rulemaking: 17 A.A.R. 264, February 18, 2011

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

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

The current rule (R9-22-712.40) requires that the fee schedule for outpatient hospital reimbursement be "rebased" every five years using the most current available Medicare cost data.

In the five years since the original adoption of the current rule, AHCCCS has identified the need to consider a number of refinements to the existing reimbursement methodology to ensure proper cost containment and provide more equitable compensation among hospitals. This rulemaking addresses some of the issues identified including, but not limited to: (1) adjusting the peer group modifiers (that is, applying a specific multiplier to the base payment otherwise payable to certain type of hospitals as described under R9-22-712.35) that are currently fixed in rule and their application to certain charges, (2) adjusting payment for outpatient observation services, (3) clarifying the payment process that reimburses hospitals for a bundle of services that span multiple dates of service as described under R9-22-712.25, and (4) clarifying settings that qualify for payment as outpatient hospital settings.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule 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:

AHCCCS analyzed Medicare cost data provided by AHCCCS participating hospitals, claims paid by AHCCCS, and encounters paid by or reported by AHCCCS managed care organizations to assist the AHCCCS Administration in arriving at the rebased figures. No formal studies by third parties were relied upon for the implementation of 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 new rules are anticipated to bring outpatient hospital cost reimbursement into a more equitable arrangement for all Arizona hospitals. The goal of the proposed rule is to establish an outpatient reimbursement methodology that contributes to an overall hospital reimbursement methodology that is consistent with efficiency, economy,

quality care and appropriate access to care. In aggregate, the total payment for hospital outpatient services is expected to remain the same.

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

No substantial 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:

Numb:	Date/ Commentor:	Comment:	Response:
1.	03/22/11 Steve Bush Tucson Medical Center (TMC)	R9-22-712.35 (B)(5) or (D) The measures exclude both Southern Arizona children's medical centers, including the region's largest pediatric program that cares for nearly 50 percent of the Southern Arizona children. Given the current language in the outlier fee structure, TMC would be excluded from the outpatient fee schedule adjustments provided to hospitals in Maricopa County. The proposed schedule calls for a rate adjustment for hospitals with more than 100 pediatric beds. That number may be appropriate for a metropolitan area such as Maricopa County, but does not match the demand for beds in Pima County. Keep in mind, of course, that Diamond Children's Medical Center at University Medical Center and TMC for Children serve the same role and function in terms of carrying for the pediatric population in Pima County as the children's hospitals and medical centers in Maricopa County.	AHCCCS' aim was to recognize the significant expense realized by a hospital that serves a large portion of our pediatric members. We determined that this would be a hospital with at least 100 pediatric beds that represent approximately 20% of the hospital's licensed beds. TMC's pediatric beds comprise 9-10% of its total licensed beds. This does not show that TMC has dedicated a large portion of its business to pediatric care.
2.	03/22/11 Steve Bush TMC	R9-22-712.35 (D) For the period January thru June 2010, TMC had the second highest number of pediatric AHCCCS patients seen in the emergency department. However, with the exclusion of NICU beds, neither of the two Southern Arizona children's medical centers meet the criteria outlined in the proposed schedule.	AHCCCS chose inpatient beds as a proxy for outpatient costs since licensed beds is a constant number that can be used immediately since they do not fluctuate from day to day and correlate with capital expenditures for pediatric care. Neonatal Intensive Care Unit (NICU) beds are more a function of obstetric care than pediatric care.

3.	03/22/11 Steve Bush TMC	TMC recommends an approach that combines inpatient and emergency department (outpatient) volumes that would be inclusive of children's medical centers throughout the state. We recommend that AHCCCS Administration consider adjusting the qualifying numbers to be 50 beds and/or more than 20,000 annual pediatric emergency department visits. This combination recognizes the importance of opening the appropriate number of beds based on community size and need. It also recognizes the important role emergency departments play in caring for the pediatric patient population.	Number of inpatient beds was chosen as a proxy to identify hospitals with high pediatric volume and correspondingly high pediatric costs. In addition, the number of inpatient beds is a more stable measure than the number of outpatient visits that may vary from year to year. Outpatient visit data is difficult to collect on a timely basis and doesn't allow for adequate reimbursement to new hospitals that intend to serve a significant number of children. Lowering the threshold to include hospitals with 50 or more pediatric beds would not achieve AHCCCS' objective of targeting hospitals with a pediatric emphasis. In addition, a lower threshold of pediatric beds would include several more hospitals and require a reduction or elimination of the adjustment because they would no longer be sufficiently unique to justify a modifier.
4.	03/22/11 Susan Watchman, Gammage and Burnham	Other than complexity, the most frequent frustrations that hospital business office staff express about the outpatient system is the timing and manner of "Table updates" to conform to Medicare coding (procedure and APC changes) or implement AHCCCS-specific coding and the inability to research historic information reliably. Our experience has been that although existing R9-22-712.40(A) states that AHCCCS ***shall*** add new procedure codes for covered outpatient procedures	Consistent with the current rule the updates and their effective dates are published on our website www.azahcccs.gov. The information provided on the website indicates whether the effective date relates to the date of service or the bill date. Consistent with A.R.S.§ 36-2903.01(B)(6) changes are published and posted to the AHCCCS website at least 30 days in advance of the effective date of the change.

		to its system, AHCCCS has been slow to update the fee schedules and reference extracts (together referred to herein as "Tables"). Moreover, it has been unclear whether AHCCCS follows Medicare with regard to when changes are effective – some Medicare changes are based on date of service, while others are effective based on bill date. Medicare coding guidelines are considered the default for legally compliant billing in the absence of published instructions from the AHCCCS Administration as the single state agency. AHCCCS policy was that bilateral procedures had to be billed on two lines with a modifier of 50. In February 2008, AHCCCS announced in the Claims Clues that it would finally adopt the billing protocol used by Medicare and commercial insurers effective January 2008. Hospitals followed the directions in the Claims Clues but their claims were denied because it was not until the Fall of 2009 that AHCCCS actually made the change to its Tables. Ultimately claims were never paid or only paid after great effort.	While this rule states that AHCCCS will adopt new procedure codes and may assign the Medicare rate to the new code, that does not mean that AHCCCS follows ***all*** Medicare billing standards or procedures. Unless an AHCCCS statute, rule or policy explicitly adopts Medicare billing standards or procedures, providers should not assume that AHCCCS follows Medicare billing standards. R9-22-712.20(C) and R9-22-712.25(C) have been modified to state that the tables and their effective dates are posted the AHCCCS website.
5.	03/22/11 Susan Watchman, Gammage and Burnham	We recognize that the dollars involved in individual lines may be small. But that is precisely why hospitals should not be "nickeled and dimed" or forced to go through cost-ineffective methods to get paid. We therefore request that AHCCCS, preferably in regulation, protect hospitals from timeliness denials due to coding discrepancies when AHCCCS has not issued explicit instructions that AHCCCS specific coding not be used, or has	The AHCCCS Administration does not have statutory authority to change the timeliness requirements or the definition of "clean claims" described in A.R.S. § 36-2904 (G).

		published conflicting information in its material and systems. We would suggest something along the lines of the following changes to R9-22-712.40: A. Procedure codes. When procedure codes are issued by CMS and added to or deleted from the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add the new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee. AHCCCS shall additionally revise or delete codes as revised or deleted by CMS. C. If a hospital bills a claim in accordance with codes issued by CMS and the claim is inconsistent with coding information posted on the AHCCCS web-site or provided to Contractors but not made publically available to providers, the claim shall not be considered an “unclean” based solely on the coding inconsistency. The Contractor or Administration when acting as payer shall be required to notify the hospital of the specific coding inconsistency that is causing the claim or a line of a claim to deny or pay less than expected. The hospital shall have sixty (60) days from notification or one year from date of service, whichever is later, to submit a revised claim. If the hospital files a claim dispute based on the code inconsistency or for any other reason, the	

		hospital to revise its claim as part of the dispute resolution process, including any case in which coding inconsistency was not the basis for the dispute but subsequently causes the claim to deny or pay less than expected after the dispute is upheld.	
6.		We have had discussions with AHCCCS staff in which we are told that changes are prospective, but which appear on the published Tables or in system information accessible only to plans with dates suggesting retrospective application. We would urge AHCCCS to make the following administrative changes: 1. Archive prior versions of Tables in a publically accessible portion of the AHCCCS web-site for at least five years. This will allow providers and plans to see code history during a claim processing or dispute process. 2. Integrate code change information currently published in both Claims Clues and Encounter Keys. 3. Neither Claims Clues or Encounter Keys are indexed or searchable, which limits their use for research. AHCCCS should all annual or semiannual indexes to these publication. 4. AHCCCS should publish notices in written material (e.g. Claims Clues or written notices to hospitals) identifying code changes that will be applied retroactively any earlier than a specified period (e.g. identify any change	As indicated by the commenter, the suggested changes are administrative and would not be appropriate for rulemaking. This suggestion will be considered for future policy clarification; however, it is beyond the scope of this rulemaking.

		retroactive more than three months prior to the announced change). 5. Impose strict oversight on plan claims projects related to adjusting OP claims that based solely on coding issues.	
7.	03/01/11 Merrick Morgan	Pursuant to section B-1 of above referenced section [R9-22-712.20] "When clinic services are billed using 51X revenue codes, the reimbursement is the difference between the facility and non-facility rates …." Does this mean that if the clinic is a hospital based clinic the hospital receives the non-facility rate plus the difference between the facility and non-facility rate? Can you explain the reimbursement please.	When clinic services are billed using 51X revenue codes, the reimbursement is the difference between the facility and non-facility rates from the physician fee schedule. Here is an example: Patient goes to physician office, physician is paid the non-facility rate, which reimburses for the procedure/service plus a bump for overhead office costs: $44.00. Patient goes to a clinic, physician is paid the facility rate, which is only the rate for the procedure/service and no bump for overhead costs: $32.00 In this second case, the facility (hospital based clinic or otherwise) would receive the difference between these two rates: $12.00 as the overhead office cost for the visit. If this is a hospital-based clinic and the hospital has a PGM, that would apply to the $12.00. In response to this comment, R9-22-712.20(B)(1) has been clarified by adding "payable to the practitioner for the procedures listed…"

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 7. STANDARDS FOR PAYMENTS

Section

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs ~~for ER and Surgery Services~~

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

~~To establish the AHCCCS Outpatient Capped Fee-For Service Schedule, AHCCCS shall:~~

A. To establish the AHCCCS Outpatient Capped Fee-For Service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-For-Service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services ~~that shall~~ to be paid under the AHCCCS Outpatient Capped Fee-For-Service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection ~~(3)~~ (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection ~~(4)~~ (A)(4) using Global Insight Health-Care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (3) (A)(3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in the most recently published CMS APC documentation. , and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
   a. The AHCCCS Non-hospital Capped Fee-For-Service Fee Schedule;
   b. ~~116%~~ 116 percent of the procedure-specific median cost AHCCCS-based fee; or
   c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
10. Compare the AHCCCS-based fee established in subsections ~~(8)~~ (A)(8) and ~~(9)~~ (A)(9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but

no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.

11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-For-Service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.

B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually in accordance with R9-22-712.40(C).

1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-Service Schedule under R9-22-710.
2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-Service Schedule. This hourly rate includes reimbursement for associated services.

C. The AHCCCS-Outpatient Capped Fee-For-Service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' website.

R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs ~~for ER and Surgery Services~~

A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.

B. Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.

~~B.~~**C.** A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services ~~is~~ including the effective date of any changes to the listing are on file and ~~available with the AHCCCS Outpatient Capped Fee-For-Service Schedule on file and online with AHCCCS~~ posted on AHCCCS' website.

R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.

B. ~~The~~ For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the ~~costing~~ method ~~defined~~ specified in ~~R9-22-712.20(3)~~ R9-22-712.20(A)(3).

C. For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-Charge Ratio or the CMS Medicare Outpatient Rural Cost-to-Charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the Federal Register on or before August 1st of that year.

~~C.~~**D.** To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied ~~times~~ by the covered charges.

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, ~~as well as~~ and hospitals that were public anytime during the calendar year 2004;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule rates are effective;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule rates are effective;
4. By 115 percent for hospitals designated as Critical Access Hospitals~~,~~ or ~~for~~ hospitals that have not been designated as Critical Access Hospitals~~,~~ but meet the criteria during the contract year in which the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule rates are effective;
5. By 113 percent for a ~~freestanding children's hospital~~ Freestanding Children’s Hospital with at least 110 pediatric beds during the contract year in which the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital~~,~~ which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the ~~outpatient capped fee schedule~~ Outpatient Capped Fee-for-Service Schedule rates are effective.

B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-Service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, which is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

~~**B.** In addition to subsection (A), the following outpatient capped fee schedule rate increase shall be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a Level 1 trauma center as defined by R9-22-2101.~~

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-Service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-Service Schedule (except for laboratory services, and out-of-state hospital services).

~~**C.**~~ **E.** Fee adjustments made under subsection (A) ~~and~~ , (B), (C) and (D) are ~~available with the AHCCCS Outpatient Capped Fee For Service Schedule, which is~~ on file with AHCCCS ~~and posted on AHCCCS' web site.~~ and current adjustments are posted on AHCCCS' web site.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(E)(2), the Medicare rate, or calculate an appropriate fee.

B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.

C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:

1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.

D. Rebase. AHCCCS shall rebase the outpatient fees every five years.

E. Statewide CCR~~.~~:

1. For begin dates of service on or before September 30, 2011, ~~The~~ the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may ~~consider recalculating~~ recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30 (C).