

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
R9-22-101	Amend
R9-22-201	Amend
R9-22-202	Amend
R9-22-210.01	Amend
R9-22-217	Amend
R9-22-1201	Amend
R9-22-1202	Amend
R9-22-1203	Amend
R9-22-1204	Amend
R9-22-1205	Amend
R9-22-1206	Repeal
R9-22-1207	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(F)

Implementing statute: A.R.S. §§ 36-2903.01(F), 36-2907, 36-2907(F) and Laws 2013, First Special Session, Chapter 10, §13.

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. 2183, August 15, 2014

Notice of Proposed Rulemaking: 20 A.A.R. 2149, August 15, 2014

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

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

HB 2634 (Laws 2011, Chapter 96) requires the Arizona Department of Health Services (ADHS) to reduce monetary or regulatory costs on persons or individuals receiving behavioral health services, streamline the regulation process, and facilitate licensure of integrated health programs that provide both behavioral and physical health services.

The Administration cross references ADHS rules and must update its rules to correctly reference changes made by ADHS. In addition, changes recommended during a 5 year review, report effective November 3, 2009, of these rules have also been made along with any technical changes required to make the rulemaking clear. Such as:

R9-22-1201 – Specify definitions that apply to this Article, and removing the authority references to statute in subsection (1) and (2).

R9-22-1202 – Clarification made to describe the Administration's responsibility in the provision of behavioral health services.

R9-22-1204 - Removed or Updated:

- Subsection (A), which defines behavioral health services, already exists in R9-22-1201 and R9-20-101.

- Subsection (B), describing medical necessity, can also be removed since it is defined in R9-22-101.
- Subsection (D), describing that EPSDT services include covered behavioral health services is also not needed since the requirement to provide behavioral health services to an EPSDT member is referred to in R9-22-213.
- Subsection (E), describing that experimental services are for purposes of research and not a behavioral health service can be removed since the same information is defined in R9-22-101 and described in R9-22-202.
- Subsection (F), describing gratuities as a non covered service can be removed since this provision is already addressed in R9-22-202.

R9-22-1205. - Removal of subsection (A)(2)(c) and (C)(5).

R9-22-1206 – Repealed since general requirements and standards for providers are covered under article 2 or article 5.

R9-22-1207 - Removed subsection (A) since this provision is addressed in contract.

Certain recommendations of changes made in the 5 year review report approved in November 2009 were no longer applicable, such as:

R9-22-1201 - Clarification of the definition “respite” to state that respite is for unpaid caregivers was not made since respite could apply to either a paid or unpaid caregiver. In addition, the cross-reference for the term “client” to reference R9-20-101 was not made since the term “client” was no longer needed due to the new terms ADHS is using.

R9-22-1204 - Subsection (K) was not clarified with provisions of restriction and limitations applicable to TRBHA’s because the restrictions and limitations apply to all behavioral health inpatient facilities and do not need to specify TRBHA.

R9-22-1206 – update to incorporations by reference were not made since this rule was repealed instead since the requirements are already explained under art 2 and art 5.

R9-22-1207 – The addition of language regarding to whom to submit a claim when a Third Party Administrator (TPA) is involved was not made because subsection (A)(6) and (A)(7) address to who and when to submit claim with a TPA.

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:

The Administration anticipates minimal economic impact on the implementing agency, small businesses and consumers; because this rulemaking was made for clarification and technical changes required as a result of ADHS rule changes. The changes made in this proposed rulemaking are not substantive changes.

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 changes that were made were as a result of the public comments received and recommendations made by GRRC staff.

In response to comments received during the public comment period, the Administration made several clarifying changes, such as:

- In R9-22-201, the phrase “except as provided under R9-22-217” was removed from several definitions specific to members other than FES members as the cross-reference was unnecessary and confusing as it references services to FES members.
- In R9-22-210.01, references to “medical services” were changed to refer to “emergency behavioral health services” because this section is intended to relate to behavioral health services for FES members.
- In R9-22-1201 and R9-22-1205, references to a “behavioral health service agency” was changed to “a behavioral health facility” to conform to the terminology in the administrative rules for behavioral health licensure adopted by ADHS.

- R9-22-1204 was amended to make it grammatically correct.

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

The following comments were received as of the close of the comment period on September 15, 2014.

Item #	Rule Cite Line #	Comment From	Comment	Analysis/ Recommendation
1.	R9-22-101	Susan Watchman 08/13/14	<p>R9-22-101(B) (Definitions)</p> <p>On page 19 of my printed copy, the definition of “Behavioral Health Professional “appears to have an incorrect reference to “A.A.C. R9-10-101, excluding subsection (g).” I cannot locate a “subsection (g).”</p>	<p>Subsection (g) is in the final filing of the ADHS rules effective July 1, 2014. See: http://www.azsos.gov/public_services/Register/2014/26/exempt.pdf</p>
2.	R9-22-201	Susan Watchman 08/13/14	<p>R9-22-201 (Scope of Service Related definitions)</p> <p>There are a series of definitions starting on page 25 and continuing on page 26 related to various aspects of emergency services. In each case the definition is restricted to “for a non-FES member” but goes onto say “except as provided under R9-22-217.” R9-22-217 is the section that deals with services to FES members. As these definitions are all for <u>non FES members</u> by their express terms, the stated exception in each case is unnecessary.</p> <p>As written the language now reads, on essence (using one example): “Emergency behavioral health services for a non FES member” means, except for services to an FES member. . .”</p>	<p>Agreed, updated language.</p>

3.	R9-22-210.01	Susan Watchman 08/13/14	<p>R9-22-210.01(A)(9)(b):</p> <p>This is the section on Notification for emergency behavioral health services for FFS members. On page 32 it reads “. . . shall notify the Administration no later than 72 hours after a FFS member receiving emergency <i>medical</i> services presents. . . .” In this context, shouldn’t it read “emergency <i>behavioral</i> services?” Also, it would be preferable use the same language as in (9)(a) above (regarding notification to ADHS or subcontractors) -- that is, “emergency inpatient behavioral health services,” unless you intend that the notification to the Administration to encompass a broader range of “emergency “ situations. Does the Administration, for example, want to be notified when patient present to the UPC? Use of different language infers different meaning and scope.</p>	Agreed, updated language.
4.	R9-22-1201	Susan Watchman 08/13/14	<p>R9-22-1201 (Definitions)</p> <p>(a) The definition of ”agency” on page 35 states that it ”means a behavioral health <i>service agency</i>, a classification of a health care institution. . . . “ To be consistent with the new ADHS regulations, I believe that should read “a behavioral health <i>facility</i>. . . .” “Facility” is the word used by ADHS licensing.</p> <p>(b) On page 37, the definition of “healthcare institution “is the same as in A.R.S. § 36-401. In other case where you lifted a definition from § 36-401 you did a simple cross reference. For consistency and legal clarity it should be the same</p>	Agreed, updated R9-22-1201 definition of “agency” and “healthcare institution”.

			here.	
5.	R9-22-1204	Susan Watchman 08/13/14	R9-22-1204(A) (General Service Requirements) The editing turned this into an ungrammatical conglomerate of concepts. It should be revised.	Agreed, revised language.
6.	R9-22-1205	Susan Watchman 08/13/14	R9-22-1205(C) & (D) The old term “agency” should be revised to “facility.”	Agreed, revised language.
7.	R9-22-1207	Susan Watchman 08/13/14	R9-22-1207 ((A)(1). The second/last sentence states “ADHS/DBHS shall require all <i>service providers</i> to submit encounters. . . “I believe this reference should be to <i>ADHS/DBHS subcontractors</i> . Providers submit claims; it’s the plans/RBHAs that submit encounters.	The Administration decided to strike subsection (A)(1) since this information is not required in rule, it is covered under statute A.R.S. §36-2904(G). In addition, A.R.S. §41-1005 states that terms of contract are not required in rule. .

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 1. DEFINITIONS

Section

R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

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

R9-22-202. General Requirements

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

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

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. ~~General Requirements~~ Definitions

R9-22-1202. ADHS, ~~and Contractor,~~ Administration and CRS Responsibilities

R9-22-1203. Eligibility for Covered Services

R9-22-1204. General Service Requirements

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

R9-22-1206. ~~General Provisions and Standards for Service Providers~~ Repeal

R9-22-1207. General Provisions for Payment

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~~

“Active treatment” R9-22-1301

“ADHS” R9-22-101

“Administration” A.R.S. § 36-2901

“Adult behavioral health therapeutic home” 9 A.A.C. 10, Article 1

“Adverse action” R9-22-101

“Affiliated corporate organization” R9-22-101

“Aged” 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501

“Agency” R9-22-1201

“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~~ R9-22-101

“Anticipatory guidance” R9-22-201

“Annual enrollment choice” R9-22-1701

“APC” R9-22-701

~~“Appellant” R9-22-101~~

“Applicant” R9-22-101 or R9-22-301

“Application” R9-22-101

“Assessment” R9-22-1101 or R9-22-1201

“Assignment” R9-22-101

“Attending physician” R9-22-101 or R9-22-202

“Authorized representative” R9-22-101

“Authorization” ~~R9-22-201~~ R9-22-202

“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 paraprofessional” R9-22-101

“Behavioral health professional” ~~A.A.C. R9-20-1201~~ R9-22-101

“Behavioral health recipient” R9-22-201

“Behavioral health ~~service~~ services” R9-22-1201

“Behavioral health technician” ~~A.A.C. R9-20-1201~~ R9-22-1201

“Benefit year” R9-22-201

“BHS” ~~R9-22-1401~~ R9-22-301

“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” R9-22-101 or R9-22-301
“Chronic” R9-22-1301
“Claim” R9-22-1101
“Claims paid amount” R9-22-712.07
“Clean claim” A.R.S. § 36-2904
“Clinical oversight” 9 A.A.C. 10
~~“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 or R9-22-210.01
“Copayment” R9-22-701, ~~R9-22-711 and R9-22-1603~~
“Cost avoid” R9-22-1201
“Cost-To-Charge Ratio” or “CCR” R9-22-701 or R9-22-712
“Court-ordered evaluation” R9-22-1201
“Court-ordered pre-petition screening” R9-22-1201
“Court-ordered treatment” R9-22-1201
“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)
“Crisis services” R9-22-1201
“Critical Access Hospital” R9-22-701
~~“CRS” R9-22-101~~
“CRS application” R9-22-1301

"CRS condition" R9-22-1301
"CRS provider" R9-22-1301
"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" R9-22-101
~~"DCSE" R9-22-1401~~
"DCSS" R9-22-301
~~"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 or R9-22-1401
"DES" R9-22-101
"Diagnostic services" R9-22-101
"Direct graduate medical education costs" or "direct program costs" R9-22-701
"Direct supervision" R9-22-1201
"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~~ a non-FES member" R9-22-201
"Emergency behavioral health services for ~~the~~ a non-FES member" R9-22-201
"Emergency medical condition for ~~the~~ a non-FES member" R9-22-201
"Emergency medical services for ~~the~~ a non-FES member" R9-22-201
"Emergency medical services provider" R9-22-1201

“Emergency medical or behavioral health condition for a FES member” R9-22-217

“Emergency services costs” A.R.S. § 36-2903.07

“Emergency services for a FES member” R9-22-217

“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~~ R9-22-301

“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~~ Freestanding Children’s Hospital” R9-22-701

“Functionally limiting” R9-22-1301

“Fund” R9-22-712.07

“Graduate medical education (GME) program” R9-22-701

“GME program approved by the Administration” or “approved GME program” R9-22-701

“Grievance” A.A.C. ~~R9-34-202~~ Chapter 34

“GSA” R9-22-101
“HCAC” R9-22-701
“HCPCS” R9-22-701
“Health care institution” A.R.S. § 36-401
“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
“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 R9-22-101
“Income” ~~R9-22-1401~~ and R9-22-301 ~~R9-22-1603~~
~~“Indigent” R9-22-1401~~
“Indirect program costs” R9-22-701
“Individual” R9-22-211
“In-kind income” R9-22-1420
“Inmate of a public institution” 42 CFR 435.1010
“Inpatient covered charges” R9-22-712.07
~~“Insured entity” R9-22-720~~
~~“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~~
“MAGI-based income” R9-22-1401
“Mailing date” R9-22-101
“Medical education costs” R9-22-701
“Medical expense deduction” or “MED” R9-22-1401
“Medical practitioner” R9-22-1201
“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~~ R9-22-301
“Medically eligible” R9-22-1301
“Medically necessary” R9-22-101
“Medicare claim” R9-22-101
~~“Medicare HMO” R9-22-101~~
“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” R9-22-701
“Member” A.R.S. § 36-2901 or R9-22-301
“Mental disorder” A.R.S. § 36-501
“Milliman study” R9-22-712.07
“Monthly equivalent” R9-22-1401, ~~R9-22-1421~~ and ~~R9-22-1603~~
“Monthly income” R9-22-1401, ~~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” R9-22-101
“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
“OPPC” 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
“Person” 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~~ R9-22-301
~~“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~~ R9-22-101
“Procedure code” R9-22-701
“Procurement file” R9-22-601
“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” or “had reason to know” R9-22-1101
“Rebase” R9-22-701
“Redetermination” R9-22-1301
“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~~ R9-22-301
“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~~ R9-22-301
“Sponsor deemed income” ~~R9-22-1401~~ R9-22-301
“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~~ R9-22-301
“Tax dependent” 42 CFR 435.4
“Taxi” A.R.S. § ~~28-2515~~ 28-101(53)
“Taxpayer” 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~~ R9-22-301
“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.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

~~“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.

“Behavioral health paraprofessional” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

- a. If the behavioral health services were provided in a setting other than a licensed health care institution,
- b. If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,
- c. If the behavioral health services were provided in a setting other than a licensed health care institution; and
- d. Are provided under supervision by a behavioral health professional R9-10-101.

“Behavioral Health Professional” has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

“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)~~ (14), 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 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..

“Taxi” is as defined in A.R.S. § ~~28-2515~~ 28-101(53).

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~~ which 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 a 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.

R9-22-202. 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~~ The Administration 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; or
 - b. A person who is in residence at an institution for the treatment of tuberculosis; ~~or~~
 - e. ~~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:~~
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.
- c. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.

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).

R9-22-210.01. 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 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 unless services are provided in an IHS or tribally operated 638 facility.
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~~ R9-22-201.
 6. Prior authorization.
 - a. Emergency behavioral health services. 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 limitation or denial of payment. A contractor, TRBHA, the Administration, 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, the Administration, 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 or the Administration.
9. Notification.
 - a. 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.
 - b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient 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.~~

~~11.10.~~ 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~~ contracted 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.

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

- A. Definition. Notwithstanding the definition in R9-22-201, for ~~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 a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in 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 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. 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.** 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 12. BEHAVIORAL HEALTH SERVICES

R9-22-1201. General Requirements Definitions

~~General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations specified in this Article.~~

- ~~1. Administration. The program shall be administered as specified in A.R.S. § 36-2903.~~
- ~~2. Provision of services. Behavioral health services shall be provided as specified in A.R.S. § 36-2907 and this Chapter.~~
- ~~3. Definitions. The following definitions apply to this Article:~~

~~“Adult behavioral health therapeutic home” as defined in 9 A.A.C. 10, Article 1.~~

~~a. “Agency” for the purposes of this Article means the same as in A.A.C. R9-20-101 a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.~~

~~“Assessment” means an analysis of a patients need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.~~

~~b. “Behavior management services” means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.~~

~~c. “Behavioral health adult therapeutic home” means a licensed behavioral health service agency that is the licensee’s residence where behavioral health adult therapeutic home care services are provided to at least one, but no more than three individuals, who reside at the residence, have been diagnosed with behavioral health issues, and are provided with food and are integrated into the licensee’s family.~~

~~d. “Behavioral health therapeutic home care services” means interactions that teach the client living, social, and communication skills to maximize the client’s ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client’s treatment plan, as appropriate.~~

- e. ~~“Behavioral health evaluation” means the assessment of a member’s medical, psychological, psychiatric, or social condition to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for all medically necessary services.~~
- f. ~~“Behavioral health medical practitioner” means a health care practitioner with at least one year of full-time behavioral health work experience.~~
- g. ~~“Behavioral health professional” means the same as in A.A.C. R9-20-101~~
- h. ~~“Behavioral health service” means a service provided for the evaluation and diagnosis of a mental health or substance abuse condition and the planned care, treatment, and rehabilitation of the member.~~
“Behavioral health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue.
- i. ~~“Behavioral health technician” means the same as in A.A.C. R9-20-101.~~
“Behavioral health technician” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that: a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and b. Are provided with clinical oversight by a behavioral health professional.
- j. ~~“Case management” for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.~~
- k. ~~“Certified psychiatric nurse practitioner” means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).~~
- l. ~~“Client” for the purposes of this rule means the same as in A.A.C. R9-22-101~~
“Clinical oversight” means as described under 9 A.A.C. 10.

m. “Cost avoid” means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

“Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.

“Court-ordered pre-petition screening” has the same meaning as “pre-petition screening” in A.R.S. § 36-501.

“Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.

“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

n. “Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

o “Licensee” means the same as in ~~A.A.C. R9-20-101~~ A.A.C. 10, Article 1.

p. “OBHL” means the same as in ~~A.A.C. R9-20-101.~~

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

q. “Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

r. “Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

- s. “Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.
- Ⓣ. “Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.
- Ⓤ. “Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.
- Ⓥ. “Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.
- Ⓦ. “TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

R9-22-1202. ADHS, ~~and Contractor,~~ Administration and CRS Responsibilities

- A. ADHS responsibilities. ~~Except as provided in subsection (B), behavioral health services shall be provided by a RBHA through a contract with ADHS/DBHS. ADHS/DBHS shall:~~
1. ~~Be responsible for providing all inpatient emergency behavioral health services for a non-FES member with a psychiatric or substance abuse diagnosis who is enrolled with a contractor in accordance with R9-22-210.01(A)(3);~~
 2. ~~Be responsible for providing all inpatient emergency behavioral health services for a non-FES/FFS member with a psychiatric or substance abuse diagnosis who is not enrolled with a contractor in accordance with R9-22-210.01(A)(3);~~
 3. ~~Be responsible for providing all non-inpatient emergency behavioral health services for a non-FES member in accordance with R9-22-210.01;~~
 4. ~~Be responsible for providing all non-emergency behavioral health services for a non-FES/FFS member;~~

5. ~~Contract with a RBHA for the provision of behavioral health services in R9-22-1205 for all Title XIX members under A.R.S. § 36-2907. ADHS/DBHS shall ensure that a RBHA provides behavioral health services to members directly, or through subcontracts, with qualified service providers who meet the qualifications specified in R9-22-1206. If behavioral health services are unavailable within a RBHA's GSA, ADHS/DBHS shall ensure that a RBHA provides behavioral health services to a Title XIX member outside the RBHA's GSA;~~
6. ~~Ensure that a member's behavioral health service is provided in collaboration with a member's primary care provider; and~~
7. ~~Coordinate the transition of care and medical records, under A.R.S. §§ 36-2903, 36-509, R9-22-512, and in contract, when a member transitions from:~~
 - a. ~~A behavioral health provider to another behavioral health provider,~~
 - b. ~~A RBHA to another RBHA,~~
 - c. ~~A RBHA to a contractor,~~
 - d. ~~A contractor to a RBHA, or~~
 - e. ~~A contractor to another contractor.~~

ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D).

B. ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for ~~Native American~~ American Indian members. ~~Native American~~ American Indian members may receive covered behavioral health services:

1. From an IHS or tribally operated 638 facility,
2. From a TRBHA, or
3. From a RBHA.

C. Contractor responsibilities. A contractor shall:

1. Refer a member to ~~an~~ a RBHA under the contract terms;
2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
3. ~~Provide inpatient emergency behavioral health services as specified in R9-22-1205 and R9-22-210.01 for a member not yet enrolled with a RBHA or TRBHA and all behavioral health services as specified in contract;~~

4. ~~Provide psychotropic medication services for a member, in consultation with the member's RBHA as needed, for behavioral health conditions specified in contract and within the primary care provider's scope of practice; and~~

5.3. ~~Coordinate a member's transition of care and medical records under subsection (A)(7).~~

D. Administration and CRS responsibilities.

1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.

2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

R9-22-1203. Eligibility for Covered Services

A. Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under ~~R9-22-1205 and R9-22-201~~ Article 12 and Article 2.

B. ~~FES members. A person who would be eligible under A.R.S. § 36-2901(6)(a)(i), A.R.S. § 36-2901(6)(a)(ii), or A.R.S. § 36-2901(6)(a)(iii) except for the failure to meet the U.S. citizenship or qualified alien status requirements under A.R.S. § 36-2903.03(A) and A.R.S. § 36-2903.03(B) is eligible for emergency services only.~~

R9-22-1204. General Service Requirements

A. Services. Behavioral health services include ~~both mental health, and substance abuse,~~ and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.

B. ~~Medical necessity. A service shall be medically necessary as provide under R9-22-201.~~

~~C. Prior authorization. A service shall be provided to a member under Title 36, Chapter 29, Article 1, by a contractor, subcontractor, or provider consistent with the prior authorization requirements in contract and the following:~~

- ~~1. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.~~
- ~~2. Non-emergency behavioral health services. When a 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 ADHS/DBHS or the RBHA/TRBHA.~~

~~**D.B.** Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.~~

~~EPSDT. For Title XIX members under age 21, EPSDT services include all medically necessary covered behavioral health services.~~

~~E. Experimental services. Experimental services and services that are provided primarily for the purpose of research are not covered.~~

~~F. Gratuities. A service or an item, if furnished gratuitously to a member, is not covered and payment to a provider shall be denied.~~

~~G. GSA. Behavioral health services rendered to a member shall be provided within the RBHA's GSA except when:~~

- ~~1. A contractor's primary care provider refers a member to another area for medical specialty care;~~
- ~~2. A member's medically necessary covered service is not available within the GSA, or~~
- ~~3. A net savings in behavioral health service delivery costs is documented by the RBHA for a member. Undue travel time or hardship for a member or a member's family is considered for a member or a member's family in determining whether there is a net savings.~~

~~H. Travel. If a member travels or temporarily resides outside of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless otherwise authorized by the member's RBHA or TRBHA.~~

~~I. Non-covered services. If a member requests a behavioral health service that is not covered or is not authorized by a RBHA or TRBHA, an AHCCCS-registered behavioral health service provider may provide the service according to R9-22-702.~~

~~J. Referral. If a member is referred outside of a RBHA's or TRBHA's service area to receive authorized, medically necessary behavioral health services, the TRBHA or RBHA is responsible for reimbursement if the claim is otherwise payable under this Chapter.~~

K.C. Restrictions and limitations.

- ~~1. The restrictions, limitations, and exclusions in this Article do not apply to a contractor, ADHS/DBHS, or a RBHA when electing to provide a noncovered service.~~
- ~~2. Room and board is not a covered service unless provided in an a behavioral health inpatient, Level 1 sub-acute, or residential facility under R9-22-1205.~~

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 and Article 2.

1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
 - a. General acute care hospital, ~~or~~
 - b. Inpatient psychiatric unit in a general acute care hospital, or
 - c. Behavioral health hospital.
2. Inpatient service limitations:
 - a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior ~~authorized~~ authorization is obtained.
 - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,

- vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A ~~behavioral health~~ medical practitioner.
- e. ~~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 benefit year as allowed under the Administration's Section 1115 Waiver with CMS.~~

B. ~~Level 1 residential treatment center services~~ Behavioral Health Inpatient facility for children. Services provided in a ~~Level 1 residential treatment center~~ Behavioral Health Inpatient facility for children as defined in ~~A.A.C. R9-20-101 9.~~ A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.

1. ~~Level 1 residential treatment center services~~ Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed ~~Level 1 residential treatment center~~ Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered Behavioral Health Inpatient facility for children ~~residential treatment center~~ services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Inpatient Residential Behavioral Health Inpatient facility for children ~~treatment center~~ service limitations.
 - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
 - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,

- vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A ~~behavioral health~~ medical practitioner.
4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
- a. Laboratory services, and
 - b. Radiology services, ~~and,~~
 - e. ~~Psychotropic medication.~~

C. Covered ~~Level 1~~ Inpatient sub-acute agency services. Services provided in a ~~Level 1~~ inpatient sub-acute agency facility as defined in ~~A.A.C. R9-20-101 9~~ A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.

- 1. ~~Level 1~~ Inpatient sub-acute agency facility services are not covered unless provided under the direction of a licensed physician in a licensed ~~Level 1~~ inpatient sub-acute agency facility that is accredited by an AHCCCS-approved accrediting body ~~as specified in contract.~~
- 2. Covered ~~Level 1~~ Inpatient sub-acute agency facility services include room and board and treatment services for behavioral health and substance abuse conditions.
- 3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A ~~behavioral health~~ medical practitioner.
- 4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:

- a. Laboratory services, and
 - b. Radiology services, and
 - e. Psychotropic medication.
5. ~~A member age 21 through 64 is eligible for behavioral health services provided in a 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 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 2 behavioral health residential agency are covered subject to the limitations and exclusions in this Article.~~
- 1. ~~Level 2 behavioral health residential agency services are not covered unless provided by a licensed Level 2 behavioral health residential agency as defined in A.A.C. R9-20-101.~~
 - 2. ~~Covered services include all services except room and board.~~
 - 3. ~~The following licensed or certified providers may bill independently for services:~~
 - a. ~~A licensed psychiatrist,~~
 - b. ~~A certified psychiatric nurse practitioner,~~
 - c. ~~A licensed physician assistant,~~
 - d. ~~A licensed psychologist,~~
 - e. ~~A licensed clinical social worker,~~
 - f. ~~A licensed marriage and family therapist,~~
 - g. ~~A licensed professional counselor,~~
 - h. ~~A licensed independent substance abuse counselor, and~~
 - i. ~~A behavioral health medical practitioner.~~
- E.** ~~Level 3 behavioral Behavioral health residential agency facility services. Services provided in a licensed Level 3 behavioral health residential agency facility as defined in 9 A.A.C. 10, Article 1 ~~A.A.C. R9-20-101~~ are covered subject to the limitations and exclusions under this Article.~~
- 1. ~~Level 3 behavioral Behavioral health residential agency facility services are not covered unless provided by a licensed Level 3 behavioral health residential agency facility.~~

2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical ~~supervision~~ oversight or direct supervision of the ~~Level 3~~ behavioral health residential ~~agency~~ facility staff whichever is applicable. Room and board are not covered services.
3. The following licensed and certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. ~~A behavioral health medical practitioner.~~

F.E. Partial care. Partial care services are covered subject to the limitations and exclusions in this Article.

1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.

G.F. Outpatient services. Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.

1. Outpatient services include the following:
 - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
 - b. ~~A behavioral health evaluation~~ behavioral health assessment provided by a behavioral health professional or a behavioral health technician;

- c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
 - d. Behavior management services as defined in R9-22-1201; and
 - e. Psychosocial rehabilitation services as defined in ~~R9-22-102~~ R9-22-201.
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 treatment center or substance abuse transitional facility clinic or a Level IV transitional agency licensed under ~~9 A.A.C. 20, Article 1-9~~ 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
 - b. A behavioral health practitioner not specified in subsections ~~(G)(2)(a)(i) through (x)~~ (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.

H.G. Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in ~~R9-22-102~~ R9-22-201.

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

- 1. Case management as defined in ~~R9-22-1201~~ 9 A.A.C. 10, Article 1;

2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. ~~Psychotropic medication and related medication~~ Medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care as described within subsection ~~(K)~~ (J);
6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in a an adult behavioral health ~~adult~~ therapeutic home as defined in ~~9 A.A.C. 20, Article 1~~ 9 A.A.C. 10, Article 1;
7. ~~Personal care services, including assistance with daily living skills and tasks, homemaking, bathing, dressing, food preparation, oral hygiene, self administration of medications, and monitoring of the behavioral health recipient's condition and functioning level provided by a licensed and AHCCCS-registered behavioral health agency or a behavioral health professional, behavioral health technician, or behavioral health paraprofessional as defined in 9 A.A.C. 20, Article 19 A.A.C. 10, Article 1; and~~
8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

~~J.I.~~ Transportation services. Transportation services are covered under R9-22-211.

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

~~R9-22-1206. General Provisions and Standards for Service Providers~~ Repeal

~~A. Qualified service provider. A qualified behavioral health service provider shall:~~

1. ~~Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;~~
2. ~~Register with the Administration as a service provider;~~
3. ~~Comply with all requirements under Article 5 and this Article.~~
4. ~~Register with ADHS/DBHS as a behavioral health service provider, and~~
5. ~~Contract with the appropriate RBHA/TRBHA.~~

~~B. Quality and utilization management.~~

- ~~1. Service providers shall cooperate with the quality and utilization management programs of a RBHA, a TRBHA, a contractor, ADHS/DBHS, and the Administration as specified in this Chapter and in contract.~~
- ~~2. Service providers shall comply with applicable procedures under 42 CFR 456, as of October 1, 2006, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC 20401. This incorporation contains no future editions or amendments.~~

R9-22-1207. General Provisions for Payment

~~A. Payment to ADHS/DBHS. The Administration shall make a monthly capitation payment to ADHS/DBHS based on the number of acute members at the beginning of each month. The Administration shall incorporate ADHS'/DBHS' administrative costs into the capitation payment.~~

B.A. Claims submissions.

- ~~1. ADHS/DBHS shall require all service providers to submit clean claims no later than the time frame specified in contract with the Administration.~~
- ~~2.1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.~~
- ~~3.2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a RBHA to the appropriate RBHA, and if not enrolled in a RBHA, to ADHS/DBHS.~~
- ~~4.3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.~~
- ~~5.4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.~~
- ~~6.5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).~~

~~7.6.~~ A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.

~~8.7.~~ ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.

C.B. Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.