

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

PREAMBLE

- 1. Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:**

August 14, 2026

- | 2. Article, Part, or Section Affected (as applicable) | Rulemaking Action |
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R9-22-101	Amend
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R9-22-201	Amend
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R9-22-207	Amend
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R9-22-209	Amend
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R9-22-212	Amend
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R9-22-213	Amend
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R9-22-215	Amend
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- 3. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

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

Implementing statute: A.R.S. §§ 36-2903.01 and 36-2907

- 4. The effective date of the rule:**

The effective date is October 7, 2026.

- a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):**

The agency has selected an immediate effective date under A.R.S. § 41-1032(A)(4) "to provide a benefit to the public and a penalty is not associated with a violation of the rule." An immediate effective date will benefit stakeholders by providing uniform access to a 12-month supply of prescription oral contraceptives in a single fill, resulting in a reduction of gaps in contraceptive coverage. An immediate effective date will support expanded refill availability for AHCCCS members aligning with the commencement of the AHCCCS contract year and will promote uniformity and ease of administration by health plans.

- b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason the agency selected the later effective date as provided in A.R.S. § 41-**

1032(B):

n/a

5. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the final rule:

Notice of Rulemaking Docket Opening: 32 A.A.R. 1578, Issue Date: July 10, 2026, Issue Number: 28, File number: (R26-113)

Notice of Proposed Rulemaking: 32 A.A.R. 1525, Issue Date: July 10, 2026, Issue Number: 28, File number: (R26-110)

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

Name: Sam McCue

Title: Senior Rules Analyst

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

Arizona Administrative Code, Title 9, Chapter 22, governs AHCCCS program administration. Article 1 contains definitions used throughout the chapter, and Article 2 establishes certain requirements, limitations and exclusions that are applicable to most, if not all, health care services provided by the program.

In 2025, the Arizona Legislature passed Senate Bill 1741, that amended A.R.S. § 36-2907, by removing cochlear implants and speech therapy in an outpatient setting from the list of excluded health and medical services for persons at least 21 years old. This statutory amendment requires AHCCCS to amend R9-22-212 to remove cochlear implants as an exclusion from covered services. This rulemaking also inserts a definition for "cochlear implants" for clarity. The statutory amendment also requires AHCCCS to amend R9-22-215 to remove speech therapy in an outpatient setting as an exclusion from covered services.

In addition, A.R.S. § 36-2907 specifically authorizes coverage for emergency dental services for AHCCCS members age 21 years and older for up to \$1,000 per contract year. The statute further authorizes coverage of dental services, contingent upon CMS approval, for persons ages 21 years and older who receive dental services at an Indian Health Service or a tribal facility and who are eligible for a 100 percent federal medical assistance percentage. These specific

limitations were not included in R9-22-207. This rulemaking amends R9-22-207 to align with these statutory provisions and amends R9-22-213 to update a cross-reference to R9-22-207.

This rulemaking amends R9-22-209 to align with the Governor's initiative that permits AHCCCS members to receive a 12-month supply of oral contraceptives in a single fill by AHCCCS registered pharmacies.

These amendments required updates to Article 1 and Article 2 definitions to add relevant terms.

This rulemaking also makes further technical and conforming adjustments as needed throughout Articles 1 and 2.

- 8. 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:**

n/a

- 9. 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:**

The rulemaking does not diminish a previous grant of authority of a political subdivision of this state.

- 10. A summary of the economic, small business, and consumer impact:**

In 2025, the Arizona Legislature passed Senate Bill 1741, that amended A.R.S. § 36-2907, by removing cochlear implants and speech therapy in an outpatient setting from the list of excluded health and medical services for persons at least 21 years old. At the time the statute was amended, it was estimated that the annual cost to the state for the removal of the exclusion for cochlear implants was approximately \$588,000 in total funds, including \$128,000 in state general funds; and to remove the exclusion of speech therapy in an outpatient setting was approximately \$836,000 in total funds, including \$146,000 in state general funds.

The Governor's initiative to provide members the option to obtain a 12-month supply of oral contraceptives in a single prescription fill has an estimated annual cost between \$270,000 and \$420,000 in total funds, including \$45,000 to \$70,000 in state general funds.

The benefits of these services provided to AHCCCS members outweigh the relatively low cost to the state.

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

n/a

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

AHCCCS did not receive any public or stakeholder comments on this rulemaking.

13. 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:

There are no other matters prescribed by statute applicable to the agency, rule or class of rules.

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:

These rules do not require the issuance of a permit, license or agency action.

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

These rules are governed by the Code of Federal Regulations, Title 42, Chapter IV, Subchapter C. These rules are not more stringent than federal law

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:

No analysis was submitted to the agency.

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

n/a

15. 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:

n/a

16. The full text of the rules follows:

Rule text begins on the next page.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

ARTICLE 1. DEFINITIONS

Section

R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

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

R9-22-207. Dental Services

R9-22-209. Pharmaceutical Services

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

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

R9-22-215. Other Medical Professional Services

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
<u>“Absent parent”</u>	<u>R9-22-1001</u>
“Accommodation”	R9-22-701
“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 <u>A.A.C. R9-10-101</u>
“Adverse action”	R9-22-101
“Affiliated corporate organization”	R9-22-101
<u>“Affiliation”</u>	<u>42 CFR 424.502</u>
“Aged”	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501

“Agency”	<u>R9-22-101</u> or 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
<u>“Amounts incurred by the system”</u>	<u>R9-22-401</u>
“Ancillary service”	R9-22-101 <u>R9-22-701</u>
“Anticipatory guidance”	R9-22-201
“Annual enrollment choice”	R9-22-1701
“APC”	R9-22-701
“Applicant”	R9-22-101 or R9-22-301
“Application”	R9-22-101
<u>“Application for eligibility”</u>	<u>R9-22-401</u>
“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”	R9-22-202
“Auto-assignment algorithm”	R9-22-1701
“AZ-NBCCEDP”	R9-22-2001
“Behavior management services”	R9-22-1201
“Behavioral health therapeutic home care services”	R9-22-1201
“Behavioral health paraprofessional”	R9-22-101
“Behavioral health professional”	R9-22-101
“Behavioral health recipient”	R9-22-201
“Behavioral health services”	R9-22-1201
“Behavioral health technician”	R9-22-1201
“Benefit year”	R9-22-201
“BHS”	R9-22-301
“Billed charges”	R9-22-701

“Blind”	R9-22-1501
“Burial plot”	R9-22-1401
“Business agent”	R9-22-701
“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
“Cash assistance”	R9-22-1401
“Certified psychiatric nurse practitioner”	R9-22-1201
“Charge master”	R9-22-712
“Child”	R9-22-1503
“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 <u>A.A.C. R9-10-101</u>
“CMDP”	R9-22-1701
“CMS”	R9-22-101
<u>“Cochlear implant”</u>	<u>R9-22-201</u>
“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
“Cost avoid”	<u>R9-22-1001</u> or R9-22-1201
“Cost To Charge Ratio” <u>“Cost-to-Charge Ratio”</u> 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) and <u>R9-22-2003</u>
“Crisis services”	R9-22-1201
“Critical Access Hospital”	R9-22-701
<u>“CRS”</u>	<u>R9-22-301</u>
“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
“DCSS”	R9-22-301
“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. <u>“EPSDT services”</u>	42 CFR 440.40(b)

“Eligibility posting”	R9-22-701
“Eligible person”	A.R.S. § 36-2901
“Emergency behavioral health condition for a non-FES member”	R9-22-201
“Emergency behavioral health services for a non-FES member”	R9-22-201
“Emergency medical condition for a non-FES member”	R9-22-201
“Emergency medical services for a non-FES member”	R9-22-201
“Emergency medical services provider”	R9-22-1201
“Emergency medical or behavioral health condition for a <u>an</u> 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
“Equity”	R9-22-101
“Experimental services”	R9-22-203
“Existing outpatient service”	R9-22-701
“Expansion funds”	R9-22-701
“FAA”	R9-22-301
“Facility”	R9-22-101
“Factor”	<u>42 CFR 447.10</u> and 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” <u>“Fee-for-service”</u> 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
“Freestanding Children’s Hospital”	R9-22-701
“Functionally limiting”	R9-22-1301
“Fund”	R9-22-712.07
“Graduate medical education (GME) program”	
<u>or “GME program”</u>	R9-22-701
“GME program approved by the Administration”	
or “approved GME program”	R9-22-701
“Grievance”	A.A.C. Chapter 34 <u>R9-34-202</u>
“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
“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”	R9-22-301
“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
“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
“MAGI-based income”	R9-22-1401
“Mailing date”	R9-22-101
<u>“Managing Employee”</u>	<u>42 CFR 455.101</u>
“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”	R9-22-101
“Medical support”	R9-22-301
“Medically eligible”	R9-22-1301
“Medically necessary”	R9-22-101
“Medicare claim”	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
“Monthly income”	R9-22-1401
“National Standard code sets ” <u>Code Sets</u> ”	R9-22-701
“New hospital”	R9-22-701

“NICU”	R9-22-701
“Noncontracted Hospital <u>hospital</u> ”	R9-22-718
“Noncontracting provider”	A.R.S. § 36-2901
“Non-FES member”	R9-22-101
“Non-IHS Acute Hospital <u>acute hospital</u> ”	R9-22-701
“Nursing facility” or “NF”	42 U.S.C. 1396r(a)
“Observation day”	R9-22-701
“Occupational therapy”	R9-22-201
“Offeror”	R9-22-101
“Operating costs”	R9-22-701
<u>“Oral contraceptives”</u>	<u>R9-22-201</u>
“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
“Partial Care <u>care</u> ”	R9-22-1201
“Participating institution”	R9-22-701
“Peer group”	R9-22-701
“Peer-reviewed study”	R9-22-2001
“Penalty”	<u>R9-22-401</u> or R9-22-1101
“Person”	R9-22-1101 <u>A.R.S. § 1-215</u>
<u>“Person with an ownership or control interest”</u>	<u>42 CFR 455.101</u>
“Pharmaceutical service <u>services</u> ”	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 <u>or R9-22-201</u>
“PPS bed”	R9-22-701
“Practitioner”	R9-22-101

“Pre-enrollment process”	R9-22-301
“Prescription”	R9-22-101
“Primary care provider” or “PCP”	R9-22-101
<u>“Primary care GME program”</u>	<u>R9-22-701</u>
“Primary care provider services”	R9-22-201
“Prior authorization”	R9-22-101
“Prior period coverage” or “PPC”	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
<u>“Qualifying health information exchange organization”</u>	<u>R9-22-701</u>
<u>“Qualified hospital”</u>	<u>R9-22-1601</u>
<u>“Quality improvement”</u>	<u>R9-22-501</u>
“Quality management”	R9-22-501
“Radiology”	R9-22-101
“RBHA” or “Regional Behavioral Health Authority”	R9-22-201 <u>A.R.S. § 36-3401</u>
“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”	R9-22-301
“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”	R9-22-718
“Rural Hospital hospital”	R9-22-712.07 and R9-22-718
“Scope of services”	R9-22-201
“Section 1115 Waiver 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”	R9-22-301
“Sponsor deemed income”	R9-22-301
“Sponsoring institution”	R9-22-701
“Spouse”	R9-22-101
“SSA”	42 CFR 1000.10
“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”	R9-22-301
<u>“System”</u>	<u>A.R.S. § 36-2901</u>
“Tax dependent”	42 CFR 435.4
“Taxi”	A.R.S. § 28-101(53)
“Taxpayer”	R9-22-1401
“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
<u>“Trip”</u>	<u>R9-22-701</u>
“Unrecovered trauma center readiness costs”	R9-22-2101
“Urban Contractor”	R9-22-718
“Urban Hospital”	R9-22-718
“USCIS”	R9-22-301
“Utilization management <u>management review</u> ”	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:

1. “ADHS” means the Arizona Department of Health Services.

2. “Adverse action” means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.
3. “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.
4. “Agency” means AHCCCS, except as otherwise provided in Article 12.
5. “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.
6. “AHCCCS registered provider” means a provider or noncontracting provider who:
- a. Enters into a provider agreement with the Administration under R9-22-703(A)₂; and
 - b. 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).~~
7. “Applicant” means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.
8. “Application” means an official request for AHCCCS medical coverage made under this Chapter.
9. “Assignment” means enrollment of a member with a contractor by the Administration.
10. “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.
11. “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:~~
- ~~If the behavioral health services were provided in a setting other than a licensed health care institution;~~
 - ~~If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33;~~
 - ~~If the behavioral health services were provided in a setting other than a licensed health care institution; and~~
 - ~~Are provided under supervision by a behavioral health professional R9-10-101.~~
12. ~~“Behavioral Health Professional”~~ health professional has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

13. “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.
14. “Case record” means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.
15. “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.
16. “CMS” means the Centers for Medicare and Medicaid Services.
17. “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.
18. “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.
19. “Contract year” means the period beginning on October 1 of a year and continuing until September 30 of the following year.
20. “Covered services” means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.
21. “Day” means a calendar day unless otherwise specified.
22. “DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.
23. “DES” means the Department of Economic Security.
24. “Diagnostic services” means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.
25. “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.~~
26. “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.
27. “Equity” means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.
28. “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.

29. “FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.
30. ~~“Fee For Service”~~ “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.
31. “FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.
32. “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).
33. “FQHC” means federally qualified health center.
34. “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.
35. “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.
36. “IHS” means Indian Health Service.
37. “IMD” ~~or “Institution for Mental Diseases”~~ means an ~~Institution for Mental Diseases~~ institution for mental diseases as described in 42 CFR 435.1010 that is licensed by ADHS.
38. “Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.
39. “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.~~
40. “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.

41. “Medical supplies” means consumable items that are designed specifically to meet a medical purpose.
42. “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 or prevent progression of 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.~~
43. “Non-FES member” means an eligible person who is entitled to full AHCCCS services.
44. “Offeror” means ~~an individual~~ a person or entity that submits a proposal to the Administration in response to an RFP.
45. “Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.
46. “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.
47. “Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.
48. “Primary care provider” or “PCP” means ~~an individual~~ a person who meets the requirements of A.R.S. § 36-2901(14), and who is responsible for the management of a member’s health care.
49. “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~~ Chapter and any applicable contract provisions. Prior authorization is not a guarantee of payment.
50. “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.
51. “Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.
52. “Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.
53. “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.
54. “Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person’s functional level.

55. “Responsible offeror” means ~~an individual~~ a person or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

56. “Responsive offeror” means ~~an individual~~ a person or entity that submits a proposal that conforms in all material respects to an RFP.

57. “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.~~

58. “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.

59. “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.

60. “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).~~

61. “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.

62. “Spouse” means a person who has entered into a contract of marriage recognized as valid by this state.

63. “SSN” means Social Security number.

64. “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.

65. “Subcontract” means an agreement entered into by a contractor with any of the following:

- a. A provider of health care services who agrees to furnish covered services to a member;
- b. A marketing organization; or
- c. Any other organization or person that agrees to perform any administrative function or service for ~~the~~ a 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. § 28-101(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:

1. “Anticipatory guidance” means ~~a person responsible for a child receives~~ the information and guidance a person responsible for a child receives ~~of what the person should expect of~~ on the expectations for the child’s development and how to ~~help keep~~ the child stay healthy.
2. “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.
3. “Benefit year” means a one-year time period of October 1st through September 30th.
4. “Cochlear implant” means an electronic hearing device implanted under the skin designed to help a person with severe to profound nerve deafness by electrically stimulating the auditory nerve inside the ear.
5. “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:
 - a. Placing the health of the person, including mental health, in serious jeopardy;
 - b. Serious impairment to bodily functions;
 - c. Serious dysfunction of any bodily organ or part; or
 - d. Serious physical harm to another person.
6. “Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.
7. “Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and delivery, 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:
 - a. Placing the member’s health in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.

8. “Emergency dental services” means dental services for an acute disorder of oral health resulting in severe pain or infection as a result of pathology or trauma.
9. “Emergency medical services for a non-FES member” members means services provided for the treatment of an emergency medical condition.
10. “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.
11. “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.
12. “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.
13. “Oral contraceptive” means a type of contraception that is taken orally to prevent pregnancy.
14. “Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.
15. “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.
16. “Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.
17. “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.
18. “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:
 - a. Living skills training;
 - b. Cognitive rehabilitation;
 - c. Health promotion;
 - d. Supported employment; and

- e. 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.~~

- 19. "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.
- 20. "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.
- 21. "Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.
- 22. "Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.
- 23. "Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:
 - a. Prevent the progression of disease, disability, or adverse health conditions; or
 - b. Prolong life and promote physical health.
- 24. "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.

R9-22-207. Dental Services

- A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B. For ~~individuals~~ members age 21 years ~~of age~~ or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
 - 1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
 - 2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or

delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

- C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
 2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.
- D.** For members age 21 years or older, the Administration or a contractor shall cover emergency dental services up to \$1,000 per member per contract year except as provided in subsection (E).
- E.** Subject to approval by the Centers for Medicare and Medicaid Services, dental services provided to American Indian or Alaska Native members age 21 years or older, who are treated at an Indian Health Service or tribal facility and who are eligible for a 100 percent federal medical assistance percentage, are not subject to the \$1,000 limit in subsection (D).

R9-22-209. Pharmaceutical Services

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
1. Available during customary business hours, and
 2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:
1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
 2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
 3. The contractor or its designee authorizes the service.
- D. The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 2. A new prescription or refill in excess of a 30 day supply is not covered unless:
 - a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; ~~or~~
 - b. ~~The Contractor~~ Except as specified in subsection (c) for oral contraceptives, the contractor authorizes the prescription for an extended time period not to exceed a 90-day supply; or

c. The new prescription or refill is for oral contraceptives. Oral contraceptives may be authorized for up to a 12-month supply provided in a single prescription fill by an AHCCCS registered pharmacy.

3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.

E. A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

A. Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and

1. Prescribed by the primary care provider, attending physician, or practitioner; or
2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
3. Authorized as required by the Administration, contractor, or contractor's designee.

B. Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.

C. Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and

1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
2. Can withstand repeated use, and
3. Is generally reusable by others.

D. Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. ~~Only those prosthetics~~ Prosthetics that are medically necessary for rehabilitation, including cochlear implants, are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:

- a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
 - b. If the member is no longer eligible for AHCCCS services; or
 - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for ~~persons~~ a person over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
- a. The member is over 3 years old and under 21 years old;
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
 - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
 - e. The member obtains incontinence briefs from providers in the contractor's network;
 - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
 - i. The member is over age 3 and under age 21;
 - ii. The member has a disability that causes incontinence of bladder or bowel, or both;
 - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
 - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. The following services are not covered for individuals 21 years of age or older:
- a. Hearing aids;
 - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
 - c. Bone Anchor Hearing Aid (BAHA);
 - d. ~~Cochlear implant;~~
 - e. d. Percussive vest;

~~f.e.~~ Insulin pump;

~~g.f. Microprocessor-controlled~~ Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and

~~h.g.~~ Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.

1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

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

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

1. Screening services including:
 - a. Comprehensive health and developmental history;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Laboratory tests; and
 - e. Health education, including anticipatory guidance;
2. Vision services including:
 - a. Diagnosis and treatment for defects in vision;
 - b. Eye examinations for the provision of prescriptive lenses;
 - c. Prescriptive lenses; and
 - d. Frames.
3. Hearing services including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment; and
 - c. Hearing aids;

4. Dental services including:
 - a. Emergency dental services as specified in ~~R9-22-207~~; R9-22-207(D) and (E);
 - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
 - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
 - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
 - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
9. Incontinence briefs as specified under R9-22-212; and
10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

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

1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.
4. Refer a member as necessary for behavioral health evaluation and treatment services.

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

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

R9-22-215. Other Medical Professional Services

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:
1. Dialysis;

2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications;
 - b. Supplies;
 - c. Devices; and
 - d. Surgical procedures;
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 6. Respiratory therapy;
 7. Ambulatory and outpatient surgery facilities services;
 8. Home health services under A.R.S. § 36-2907(D);
 9. Private or special duty nursing services;
 10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
 12. Chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
 2. Dialysis shunt placement;
 3. Arteriovenous graft placement for dialysis;
 4. Angioplasties or thrombectomies of dialysis shunts;
 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
 6. Eye surgery for the treatment of diabetic retinopathy;
 7. Eye surgery for the treatment of glaucoma;
 8. Eye surgery for the treatment of macular degeneration;

9. Home health visits following an acute hospitalization (limited up to five visits);
10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
11. Physical therapy subject to the limitation in subsection (C);
12. Facility services related to wound debridement;
13. Apnea management and training for premature babies up to the age of 1; and
14. Other services identified by the Administration through the Provider Participation Agreement.

C. The following are not covered services:

1. Occupational ~~and speech therapies~~ therapy provided on an outpatient basis for a member age 21 or older;
2. Abortion counseling;
3. Services or items furnished solely for cosmetic purposes;
4. Services provided by a podiatrist; or
5. More than 15 outpatient physical therapy visits per benefit year for ~~persons~~ a person age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
6. More than 15 outpatient physical therapy visits per benefit year for ~~persons~~ a person age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquire