Unofficial version of the rules in 9 A.A.C. 11, effective November 7, 2022

TITLE 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTION FACILITY AND HEALTH PROFESSIONALS WORKFORCE DATA

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ARTICLE 1. DEFINITIONS

R9-11-101. Definitions

In this Chapter, unless otherwise specified:

1. "Admission" or "admitted" means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
2. "AHCCCS" means the Arizona Health Care Cost Containment System, established under A.R.S. § 36-2902.
3. "Allowance" means a charity care discount, self-pay discount, or contractual adjustment.
4. "Arizona facility ID" means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.
5. "Assisted living facility" means the same as in A.R.S. § 36-401.
6. "Attending provider" means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
7. "Available bed" means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
8. "Bill" means a statement for money owed to a health care institution for the provision of the health care institution's services.
9. "Business day" means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
10. "Calendar day" means any day of the week, including a Saturday or a Sunday.
11. "Cardiopulmonary resuscitation" means the same as in A.R.S. § 36-3251.
12. "Charge" means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.
13. "Charge source" means the unit within a health care institution that provided services to an individual for which the individual's payer source is billed.
14. "Charity care" means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
15. "Chief administrative officer" means the same as in A.A.C. R9-10-101.
16. "Chief financial officer" means an individual who is responsible for the financial records of a health care institution.
17. "Classification" means a designation that indicates the types of services a hospital provides.
18. "Clinical evaluation" means an examination performed by a medical practitioner on the body of

an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.

19. "Code" means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.
20. "Commodity" means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.
21. "Contractual adjustment" means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.
22. "Control number" means a unique number assigned by a hospital for an individual's specific episode of care.
23. "Department" means the Arizona Department of Health Services.
24. "Designee" means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.
25. "Diagnosis" means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual's current medical condition.
26. "Discharge" means a health care institution's termination of services to a patient or resident for a specific episode of care.
27. "Discharge status" means the disposition of a patient, including whether the patient:
    a. Was discharged home,
    b. Was transferred to another health care institution, or
    c. Died.
28. "DNR" means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient's heart stops beating.
29. "Electronic" means the same as in A.R.S. § 36-301.
30. "Emergency" means the same as in A.A.C. R9-10-101.
31. "Emergency department" means the unit within a hospital that is designed for the provision of emergency services.
32. "Emergency services" means the same as in A.A.C. R9-10-101.
33. "Episode of care" means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.
34. "Fiscal year" means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.

35. "Governing authority" means the same as in A.R.S. § 36-401.
36. "Health care institution" means the same as in A.R.S. § 36-401.
37. "Health-related services" means the same as in A.R.S. § 36-401.
38. "Home health agency" means the same as in A.R.S. § 36-151.
39. "Home health services" means the same as in A.R.S. § 36-151.
40. "Home office" means the person that is the owner of and controls the functioning of a nursing care institution.
41. "Hospice" means the same as in A.R.S. § 36-401.
42. "Hospital" means the same as in A.A.C. R9-10-101.
43. "Hospital administrator" means the same as "chief administrative officer" or "administrator" in A.A.C. R9-10-101.
44. "Hospital services" means the same as in A.A.C. R9-10-201.
45. "Inpatient" means an individual admitted to a hospital and billed as an inpatient according to the hospital's policies and procedures.
46. "International Classification of Diseases Code" means a code included in a set of codes such as the ICD-10-CM codes, which is used by a hospital for billing purposes.
47. "Licensed capacity" means the same as in A.R.S. § 36-401.
48. "Management company" means an entity that:
    a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution,
    b. Takes direction from the governing authority of the nursing care institution, and
    c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
49. "Medical practitioner" means an individual who is:
    a. Licensed:
        i. As a physician;
        ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
        iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
        iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
        v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
        vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or
    b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.

50. "Medical record number" means a unique number assigned by a hospital to an individual for identification purposes.
51. "Medical services" means the same as in A.R.S. § 36-401.
52. "Medicare" means a federal health insurance program established under Title XVIII of the Social Security Act.
53. "National provider identifier" means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.
54. "Newborn" means a human:
    a. Whose birth took place in the reporting hospital, or
    b. Who was:
        i. Born outside a hospital,
        ii. Admitted to the reporting hospital within 24 hours of birth, and
        iii. Admitted to the reporting hospital before being admitted to any other hospital.
55. "Nursing care institution" means the same as in A.R.S. § 36-446.
56. "Nursing care institution administrator" means the same as in A.R.S. § 36-446.
57. "Nursing services" means the same as in A.R.S. § 36-401.
58. "Patient" means the same as in A.A.C. R9-10-101.
59. "Payer source" means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.
60. "Physician" means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
61. "Principal diagnosis" means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.
62. "Principal procedure" means the procedure judged by an individual working on behalf of a hospital to be:
    a. The most significant procedure performed during an episode of care, or
    b. The procedure most closely associated with a patient's principal diagnosis.
63. "Priority of visit" means the urgency with which a patient required medical services during an episode of care.
64. "Procedure" means a set of activities performed on a patient that:
    a. Is intended to diagnose or treat a disease, illness, or injury;

b. Requires the individual performing the set of activities be trained in the set of activities; and

c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.

65. "Prospective payment system" means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.

66. "Refer" means to direct an individual to a health care institution for services provided by the health care institution.

67. "Referral source" means a code designating the entity that referred or transferred a patient to a hospital.

68. "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.

69. "Reporting period" means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.

70. "Residence" means the place where an individual lives, such as:

a. A private home,

b. A nursing care institution, or

c. An assisted living facility.

71. "Resident" means the same as in A.A.C. R9-10-101.

72. "Revenue code" means a code for a unit of service that a hospital includes on a bill for hospital services.

73. "Secondary diagnosis" means any diagnosis for an individual other than the principal diagnosis.

74. "Self-pay discount" means a reduction in charges billed to an individual.

75. "Service" means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.

76. "Supportive services" means the same as in A.R.S. § 36-151.

77. "Transfer" means discharging an individual from a health care institution so the individual may be admitted to another health care institution.

78. "Trauma center" means the same as in:

a. A.R.S. § 36-2201, or

b. A.R.S. § 36-2225.

79. "Treatment" means the same as in A.A.C. R9-10-101.

80. "Type of" means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:

a. An employee or contracted worker;

b. An accounting concept, such as asset, liability, or revenue;

c. A non-covered ancillary charge;

d. A payer source;

e. A charge source;

f. A medical condition; or

g. A service.

81. "Type of bed" means a category of available bed that specifies the services provided to an individual occupying the available bed.

82. "Unit" means an area within a health care institution that is designated by the health care institution to provide a specific type of service.

83. "Unit of service" means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.

84. "Written notice" means a document that is provided:

a. In person,

b. By delivery service,

c. By facsimile transmission,

d. By electronic mail, or

e. By mail.

ARTICLE 2. ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

R9-11-201. Definitions

In this Article, unless otherwise specified:

1. "Accredited" means the same as in A.R.S. § 36-422.
2. "ALTCS" means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. "Asset" means the same as "asset" in generally accepted accounting principles.
4. "Audit" means the same as "audit" in generally accepted accounting principles.
5. "Bereavement services" means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual's death.
6. "Building improvement" means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
7. "Caseload" means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
8. "Certified nursing assistant" means the same as "nursing assistant" in A.R.S. § 32-1601.
9. "Chaplain" means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient's family.
10. "Continuous care" means hospice services provided in a patient's residence to a patient who requires nursing services to be available 24 hours a day.
11. "Contracted worker" means an individual who:
    a. Performs:
        i. Hospital services in a hospital,
        ii. Nursing services or health-related services in a nursing care institution,
        iii. Hospice services for a hospice, or
        iv. Labor as a medical record coder or transcriptionist for a hospital; and
    b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.
12. "Covered services" means hospice services that are provided to an individual by a hospice and are paid for by a payer source.
13. "Daily census" means a count of the number of patients to whom hospice services were provided during a 24-hour period.
14. "Direct care" means services provided to a resident that require hands-on contact with the

resident.

15. "Direction" means the same as in A.R.S. § 36-401.
16. "Employee" means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.
17. "Employee-related expenses" means costs incurred by an employer to pay for the employer's portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.
18. "Equity" means the same as "equity" in generally accepted accounting principles.
19. "Expense" means the same as "expense" in generally accepted accounting principles.
20. "Free-standing" means that a health care institution does not operate as part of another health care institution.
21. "FTE" means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.
22. "Generally accepted accounting principles" means the set of financial reporting standards administered by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or other specialized bodies dealing with accounting and auditing matters.
23. "Health professional" means the same as in A.R.S. § 32-3201.
24. "Hospice administrator" means the chief administrative officer for a hospice.
25. "Hospice chief financial officer" means an individual who is responsible for the financial records of a hospice.
26. "Hospice inpatient facility" means the same as in A.A.C. R9-10-101.
27. "Hospice services" means the activities described in A.A.C. R9-10-612.
28. "Hospice service agency" means the same as in A.R.S. § 36-401.
29. "Income" means the same as "income" in generally accepted accounting principles.
30. "Inpatient services" means sleeping accommodations and assistance, such as personal care and food preparation, provided to a patient at one of the following health care institutions:
    a. A hospice inpatient facility licensed under 9 A.A.C. 10, Article 6;
    b. A hospital licensed under 9 A.A.C. 10, Article 2; or
    c. A nursing care institution licensed under 9 A.A.C. 10, Article 4.
31. "Level of care" means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.
32. "Liability" means the same as "liability" in generally accepted accounting principles.
33. "Licensed nurse" means a registered nurse practitioner, registered nurse, or practical nurse.
34. "Licensee" means the same as in R9-10-101.
35. "Median length of stay" means the midpoint in the number of patient care days for all patients

who were discharged from a hospice during a specific period of time.

36. "Medicaid" means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.
37. "Medical record coder" means an individual who assigns codes to a patient's diagnoses and procedures for billing purposes.
38. "Medical record transcriptionist" means an individual who copies and edits dictation from medical practitioners into medical records.
39. "Medical records" mean the same as in A.R.S. § 12-2291.
40. "Medicare cost report" means the annual financial and statistical documents submitted to the United States Department of Health and Human Services as required by Title XVIII of the Social Security Act.
41. "Medicare-certified" means that a health care institution is authorized by the United States Department of Health and Human Services to bill Medicare for services provided to patients or residents who are eligible to receive Medicare.
42. "Midnight census" means a count of the number of patients or residents in a health care institution at 12:00 a.m.
43. "Net assets" means the same as "net assets" in generally accepted accounting principles.
44. "Non-covered ancillary services" means activities, such as rehabilitation services, laboratory tests, or x-rays, provided to an individual in a health care institution that are paid for by:
    a. A payer source other than ALTCS, or
    b. ALTCS to an entity that is not a health care institution.
45. "Nursery patient" means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital's licensed capacity.
46. "Nursing personnel" means the individuals authorized by a health care institution to provide nursing services to a patient or resident.
47. "Occupancy rate" means the midnight census divided by the number of available beds, expressed as a percent.
48. "Operating expense" means the same as "operating expense" in generally accepted accounting principles.
49. "Outpatient hospice services" means hospice services provided at a location outside a hospice inpatient facility.
50. "Owner" means the same as in A.A.C. R9-10-101.
51. "Patient care day" means a calendar day during which a hospice provides hospice services to a patient.
52. "Patient day" means a period during which a patient received inpatient services with:

a. The time between the midnight census on two successive calendar days counting as one period, and

b. The day of discharge being counted only when the patient is admitted and discharged on the same day.

53. "Person" means the same as in A.R.S. § 41-1001.

54. "Practical nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.

55. "Registered nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.

56. "Rehabilitation services" means the same as in A.A.C. R9-10-101.

57. "Resident day" means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:

a. The time between the midnight census on two successive calendar days counting as one period, and

b. The day of discharge being counted only when the resident is admitted and discharged on the same day.

58. "Respite care services" means the same as in A.R.S. § 36-401.

59. "Revenue" means the same as "revenue" in generally accepted accounting principles.

60. "Routine home care" means hospice services provided in a patient's residence to a patient who does not require nursing services to be available 24 hours a day.

61. "Rural" means the same as in A.R.S. § 36-2171.

62. "Self-pay" means that charges for hospice services are billed to an individual.

63. "Social worker" means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.

64. "Statement of cash flows" means the same as "statement of cash flows" in generally accepted accounting principles.

65. "Surgery" means the excision of a part of a patient's body or the incision into a patient's body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.

66. "Turnover rate" means:

a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the hospital during a reporting period by the average number of individuals employed during the reporting period; or

b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a

reporting period by the average number of employees during the reporting period.

67. "Uniform accounting report" means a document that meets the requirements of A.R.S. § 36-125.04 and contains the information required in R9-11-203 for hospitals, R9-11-204 for nursing care institutions, and R9-11-205 for hospices.
68. "Unscheduled medical services" means the same as in A.R.S. § 36-401.
69. "Urban" means an area not defined as "rural."
70. "Urgent care unit" means a facility under a hospital's license that is:
    a. Located within one-half mile of the hospital, and
    b. Designated by the hospital for the provision of unscheduled medical services for medical conditions that are of a less critical nature than emergency medical conditions.
71. "Vacancy rate" means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital's reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital's reporting period.
72. "Volunteer" means the same as in A.A.C. R9-10-101.

R9-11-202. Hospital Annual Financial Statement

A. A hospital administrator or designee shall submit to the Department, no later than 120 calendar days after the ending date of the hospital's fiscal year:
1. An annual financial statement prepared according to generally accepted accounting principles;
2. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (A)(1); and
3. An attestation, signed and dated by the hospital administrator or designee, that the hospital is not passing on the cost of the hospital assessment, established in A.R.S. § 36-2901.08(A), to a patient or a third-party payor that is responsible for paying for the patient's care.

B. If a hospital is part of a group of health care institutions that prepares a combined annual financial statement and is included in the combined annual financial statement, the hospital administrator or designee may submit the combined annual financial statement if the combined annual financial statement:
1. Is prepared according to generally accepted accounting principles,
2. Identifies the hospital, and
3. Contains a financial statement specific to the hospital.

C. The Department shall grant a hospital a 30-day extension for submitting an annual financial statement and report of the audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:
1. Includes the name, physical address, mailing address, and telephone number of the hospital;

2. Includes the name, telephone number, mailing address, and e-mail address of:
   a. The hospital administrator; and
   b. An individual, in addition to the hospital administrator, who may be contacted about the extension request;
3. Includes the date the hospital's annual financial statement and audit of the annual financial statement is due to the Department;
4. Specifies that the hospital is requesting a 30-day extension from submitting the annual financial statement and report of the audit of the annual financial statement required in subsection (A); and
5. Is submitted to the Department at least 30 calendar days before the annual financial statement and report of the audit of the annual financial statement is due to the Department.

D. The Department shall send a written notice of approval of a 30-day extension to a hospital that submits a request for an extension that meets the requirements specified in subsection (C) within seven business days after receiving the request.

E. If a request by a hospital administrator or designee for a 30-day extension does not meet the requirements specified in subsection (C), the Department shall provide to the hospital a written notice that specifies the missing or incomplete information. If the Department does not receive the missing or incomplete information within 10 calendar days after the date on the written notice, the Department shall consider the hospital's request withdrawn.

F. Before the end of the 30-day extension specified in subsection (C), a hospital administrator or designee may request an additional extension for submitting an annual financial statement and report of the audit of the annual financial statement by submitting a written request that:

1. Includes the information specified in subsections (C)(1) through (C)(3),
2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and report of the audit of the annual financial statement,
3. Is submitted to the Department at least 14 calendar days before the annual financial statement and report of the audit of the annual financial statement is due to the Department, and
4. Includes the reasons for the additional extension request.

G. In determining whether to approve or deny a request for a hospital to receive an additional extension as specified in subsection (F) for submitting an annual financial statement and report of the audit of the annual financial statement, the Department shall consider the following:

1. The reasons for the additional extension request provided according to subsection (F)(4);
2. The length of time for which the additional extension is being requested according to subsection (F)(2); and
3. If the hospital has a history of the following items:

a. Repeated violations of the same statutes or rules,

b. Patterns of noncompliance with statutes or rules,

c. Types of violations of statutes or rules,

d. Total number of violations of statutes or rules,

e. Length of time during which violations of statutes or rules have been occurring, and

f. Noncompliance with an agreement between the Department and the hospital.

H. The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and report of the audit of the annual financial statement within seven business days after receiving the request.

I. If the Department denies a request for an additional extension specified in subsection (F), a hospital may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

J. If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-203. Hospital Uniform Accounting Report

A. A hospital administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the hospital's fiscal year.

B. A hospital administrator or designee shall submit a copy of the hospital's Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospital;
2. The name, telephone number, and e-mail address of the:
   a. Hospital administrator,
   b. Hospital chief financial officer, and
   c. Individual who prepared the uniform accounting report;
3. The identification number assigned to the hospital:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the hospital's national provider identifier;
4. The hospital's classification;
5. Whether the entity that is the owner of the hospital is:
   a. Not for profit;

b. For profit; or

c. A federal, state, or local government agency;

6. Whether or not the hospital is Medicare-certified;

7. The beginning and ending dates of the hospital's reporting period;

8. If the hospital began operations during the hospital's reporting period, the date on which the hospital began operations;

9. The date the uniform accounting report was submitted to the Department;

10. The licensed capacity, for each type of bed, at the end of the reporting period;

11. The licensed capacity at the end of the reporting period;

12. The number of available beds, for each type of bed, at the end of the reporting period;

13. The number of available beds at the end of the reporting period;

14. The number of admissions, for each type of bed, during the reporting period;

15. The total number of admissions during the reporting period;

16. The total number of patient days:

a. During the reporting period, and

b. For each type of bed during the reporting period;

17. The average occupancy rate for the reporting period;

18. The number of surgeries during the reporting period that required a patient to receive inpatient services in the hospital;

19. The number of surgeries during the reporting period that did not require a patient to receive inpatient services in the hospital;

20. The number of births during the reporting period;

21. The number of nursery patient admissions during the reporting period;

22. The number of patient days for nursery patients during the reporting period;

23. The number of episodes of care during the reporting period provided by the:

a. Emergency department,

b. Urgent care unit, and

c. Trauma center;

24. The total number of episodes of care during the reporting period provided by the emergency department, urgent care unit, or trauma center;

25. The number of episodes of care in the emergency department, urgent care unit, or trauma center during the reporting period for which the patient was subsequently admitted to the hospital;

26. The total number of FTEs at the end of the reporting period;

27. The turnover rate for the reporting period;

28. The vacancy rate for the reporting period;

29. The number of FTEs, for each type of employee, during the reporting period;
30. The vacancy rate, for each type of employee, for the reporting period;
31. The number of medical record coder FTEs during the reporting period;
32. The vacancy rate for medical record coders for the reporting period;
33. The number of medical record transcriptionist FTEs during the reporting period;
34. The vacancy rate for medical record transcriptionists for the reporting period;
35. For individuals who worked for the hospital as contracted workers during the reporting period, the number of hours worked by registered nurses;
36. The amount of revenue generated, for each type of revenue, by the hospital during the reporting period;
37. The amount of allowances given, for each type of allowance, by the hospital during the reporting period;
38. The total amount of revenue generated and allowances given by the hospital during the reporting period;
39. The operating expenses incurred, for each type of operating expense, by the hospital during the reporting period;
40. The total operating expenses incurred by the hospital during the reporting period;
41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospital during the reporting period;
43. The amount of assets, for each type of asset, of the hospital at the end of the reporting period;
44. The total amount of assets of the hospital at the end of the reporting period;
45. The amount of liabilities, for each type of liability, of the hospital at the end of the reporting period;
46. The total amount of liabilities of the hospital at the end of the reporting period;
47. The amount of net assets, for each type of net asset, of the hospital at the end of the reporting period;
48. The total amount of net assets of the hospital at the end of the reporting period;
49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and
50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3), unless the statement of cash flows has been submitted as part of the annual financial statement required in R9-11-202.

D. A hospital administrator or designee shall:

1. On a form provided by the Department:

a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted ac-cording to subsections (B) and (C) is accurate and complete; or

b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:

i. Identify the information that is not accurate or not complete;

ii. Describe the circumstances that make the information not accurate or not complete;

iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and

iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospital administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-204. Nursing Care Institution Uniform Accounting Report

A. A nursing care institution administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the nursing care institution's fiscal year.

B. A nursing care institution administrator or designee shall submit a copy of the nursing care institution's Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the nursing care institution;

2. The name, physical address, mailing address, and telephone number of the nursing care institution's:
   a. Home office, if applicable; and
   b. Management company, if applicable;
3. An alternative name under which the nursing care institution provides nursing services or health-related services, if applicable;
4. The identification number assigned to the nursing care institution:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the nursing care institution's national provider identifier;
5. The name, telephone number, and e-mail address of the:
   a. Nursing care institution administrator;
   b. Nursing care institution chief financial officer;
   c. Individual who prepared the uniform accounting report; and
   d. Individual whom the Department may contact about the uniform accounting report at the:
      i. Home office, if applicable; and
      ii. Management company, if applicable;
6. The beginning and ending dates of the nursing care institution's reporting period;
7. If the nursing care institution began operations during the nursing care institution's reporting period, the date on which the nursing care institution began operations;
8. The date the uniform accounting report was submitted to the Department;
9. Whether the entity that is the owner of the nursing care institution is:
   a. Not for profit;
   b. For profit; or
   c. A federal, state, or local government agency;
10. Whether or not the nursing care institution is Medicare-certified;
11. The licensed capacity at the beginning and end of the reporting period;
12. The total number of available beds at the beginning and end of the reporting period;
13. If the nursing care institution has a distinct unit for patients whose payer source is Medicare, the number of licensed beds in that unit at the beginning and end of the reporting period;
14. The number of resident admissions during the reporting period;
15. The number of resident days during the reporting period:
    a. For each payer source that is not ALTCS, and

b. For each level of care for residents whose payer source is ALTCS;

16. The total number of resident days during the reporting period;

17. The average occupancy rate for the reporting period;

18. The number of paid hours during the reporting period for each of the following types of employees:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

19. The number of hours worked during the reporting period by each of the following types of employees:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

20. The amount in salaries paid, excluding employee-related expenses, for each of the following types of employees:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

21. The number of each of the following types of employees at the beginning of the reporting period:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

22. The number of each of the following types of employees at the end of the reporting period:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

23. For staff employed by the nursing care institution during the reporting period as registered nurses, practical nurses, or certified nursing assistants, the total:

a. Number of paid hours;

b. Number of hours worked;

c. Amount in salaries paid, excluding employee-related expenses;

d. Number of staff at the beginning of the reporting period; and

e. Number of staff at the end of the reporting period;

24. The turnover rate for the reporting period for:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

25. The total turnover rate for the reporting period for all employees of the nursing care institution who are registered nurses, practical nurses, or certified nursing assistants;

26. The number of hours worked during the reporting period by each of the following types of contracted workers:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

27. The total number of hours worked during the reporting period by contracted workers who are registered nurses, practical nurses, or certified nursing assistants;

28. The amount paid during the reporting period for each of the following types of contracted workers:

a. Registered nurses,

b. Practical nurses, and

c. Certified nursing assistants;

29. The total amount paid during the reporting period to contracted workers who are registered nurses, practical nurses, or certified nursing assistants;

30. The amount of revenue generated and allowances given, for each type of revenue or allowance, by the nursing care institution during the reporting period;

31. The total amount of revenue generated and allowances given by the nursing care institution during the reporting period;

32. The operating expenses incurred by the nursing care institution during the reporting period for each type of operating expense;

33. The total operating expenses incurred by the nursing care institution during the reporting period;

34. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the nursing care institution during the reporting period;

35. The charges for non-covered ancillary services during the reporting period:

a. For each type of non-covered ancillary service,

b. For each type of payer source, and

c. For each type of non-covered ancillary service for each type of payer source;

36. The total amount of non-covered ancillary charges for the reporting period;

37. If the nursing care institution has documentation of building improvement costs that:

a. Affected the licensed capacity:

i. The year in which each building improvement was completed;

ii. The cost of each building improvement;

iii. The licensed capacity before the building improvement was begun;

iv. The number of beds that were added as a result of the building improvement, if applicable;

v. The number of beds that were removed as a result of the building improvement, if applicable; and

vi. The licensed capacity after the building improvement was completed; and

b. Did not affect the licensed capacity:

i. The year in which each building improvement was completed; and

ii. The cost of each building improvement;

38. The amount of assets, for each type of asset, of the nursing care institution at the end of the reporting period;

39. The total amount of assets of the nursing care institution at the end of the reporting period;

40. The amount of liabilities, for each type of liability, of the nursing care institution at the end of the reporting period;

41. The total amount of liabilities of the nursing care institution at the end of the reporting period;

42. The amount of equity, for each type of equity, of the nursing care institution at the end of the reporting period;

43. The total amount of equity of the nursing care institution at the end of the reporting period;

44. The difference between the amount identified in subsection (C)(43) and the amount identified in subsection (C)(41); and

45. An equity reconciliation statement, including:

a. Net equity at the beginning of the reporting period;

b. The difference between the amount identified in subsection (C)(31) and the amount identified in subsection (C)(33);

c. Additions to equity, for each type of additional equity, for the reporting period;

d. The total amount of additional equity for the reporting period;

e. Deductions from equity, for each type of equity deduction, for the reporting period;

f. The total amount of equity deduction for the reporting period; and

g. Net equity at the end of the reporting period.

D. A nursing care institution administrator or designee shall:

1. On a form provided by the Department:

a. Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or

b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:

i. Identify the information that is not accurate or not complete;

ii. Describe the circumstances that make the information not accurate or not complete;

iii. State what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and

iv Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A nursing care institution administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a nursing care institution administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-205. Hospice Uniform Accounting Report

A. A hospice administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, within 150 calendar days after the end of the hospice's fiscal year.

B. A hospice administrator or designee shall submit a copy of the hospice's Medicare and Medicaid cost reports, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospice;

2. The identification number assigned to the hospice:

a. By the Department;

b. By AHCCCS, if applicable;

c. By Medicare, if applicable; and

d. As the hospice's national provider identifier;

3. The beginning and ending dates of the hospice's reporting period;

4. If the hospice began operations during the hospice's reporting period, the date on which the hospice began operations;

5. The name, telephone number, and e-mail address of the:

a. Hospice administrator,

b. Hospice chief financial officer, and

c. Individual who prepared the uniform accounting report;

6. The date the uniform accounting report was submitted to the Department;

7. Whether the hospice operates as a:

a. Hospice service agency, or

b. Hospice service agency with one or more hospice inpatient facilities;

8. Whether the entity that is the owner of the hospice is:

a. Not for profit;

b. For profit; or

c. A federal, state, or local government agency;

9. Whether or not the hospice is Medicare-certified;

10. The entity by which the hospice is accredited, if applicable;

11. Whether the hospice provides hospice services in an area that:

a. Is equal to or more than two-thirds urban,

b. Is equal to or more than two-thirds rural, or

c. Is less than two-thirds urban and less than two-thirds rural;

12. If the hospice operates one or more hospice inpatient facilities, list for each hospice inpatient facility:

a. The identification number assigned to the hospice inpatient facility by the Department;

b. The levels of care provided;

c. The licensed capacity of the hospice inpatient facility;

d. The total number of available beds at the beginning and end of the reporting period; and

e. The average occupancy rate for the reporting period;

13. The number of patients during the reporting period that were:

a. Referred to the hospice,

b. Admitted to the hospice,

c. Died while admitted to the hospice, and

d. Discharged from the hospice while living;

14. The number of patient care days, for all patients, during the reporting period in which the hospice provided:

a. Routine home care,

b. Respite care services,

c. Continuous care, and

d. Inpatient services;

15. The total number of patient care days during the reporting period for all patients;

16. The average daily census for the reporting period, calculated as the number specified in subsection (C)(15) divided by the number of days in the reporting period;

17. Average length of stay, calculated as the number of patient care days for patients discharged during the reporting period divided by the sum of the numbers specified in subsections (C)(13)(c) and (C)(13)(d);

18. Median length of stay for patients discharged during the reporting period;

19. The number of patients admitted to the hospice during the reporting period:

a. By gender;

b. By age group;

c. By race and ethnicity;

d. From:

i. A private home owned or leased by, or on behalf of, a patient;

ii. An assisted living facility;

iii. A nursing care institution;

iv. A hospital; and

v. A hospice;

e. With a principal diagnosis of:

i. Cancer,

ii. Heart disease,

iii. Dementia,

iv. Lung disease,

v. Kidney disease,

vi. Stroke or coma,

vii. Liver disease,

viii. HIV-related disease,

ix. Motor neuron disorder,

x. Unspecified debility, and

xi. A disease not specified in subsections (C)(19)(e)(i) through (C)(19)(e)(x); and

f. Whose payer source is:

i. Medicare,

ii. AHCCCS,

iii. Self-pay,

iv. A private insurance company, and

v. A payer source not specified in subsections (C)(19)(f)(i) through (C)(19)(f)(iv);

20. The total number of patient care days during the reporting period that the hospice provided hospice services to a patient whose principal diagnosis was related to:

a. Cancer,

b. Heart disease,

c. Dementia,

d. Lung disease,

e. Kidney disease,

f. Stroke or Coma,

g. Liver disease,

h. HIV-related disease,

i. Motor neuron disorder,

j. Unspecified debility, and

k. Any other disease not specified in subsections (C)(20)(a) through (C)(20)(j);

21. The number of FTEs providing hospice services, for each type of employee, during the reporting period;

22. The total number of FTEs providing hospice services during the reporting period;

23. The average caseload during the reporting period for a licensed nurse, calculated as the total number of patients assigned to licensed nurses working for the hospice during the reporting period, divided by the total number of licensed nurses working for the hospice during the reporting period, for:

a. Outpatient hospice services, and

b. Hospice services provided in hospice inpatient facilities;

24. The average caseload during the reporting period for a social worker, calculated as the total number of patients assigned to social workers working for the hospice during the reporting period, divided by the total number of social workers working for the hospice during the reporting period, for:

a. Outpatient hospice services, and

b. Hospice services provided in hospice inpatient facilities;

25. The average caseload during the reporting period for nursing personnel other than a licensed nurse, calculated as the total number of patients assigned to nursing personnel other than licensed nurses working for the hospice during the reporting period, divided by the total number of nursing personnel other than licensed nurses working for the hospice during the reporting period, for:
    a. Outpatient hospice services, and
    b. Hospice services provided in hospice inpatient facilities;
26. The average caseload during the reporting period for a chaplain, calculated as the total number of patients assigned to chaplains working for the hospice during the reporting period, divided by the total number of chaplains working for the hospice during the reporting period, for:
    a. Outpatient hospice services, and
    b. Hospice services provided in hospice inpatient facilities;
27. The number of individuals who received bereavement services from the hospice during the reporting period;
28. The number of individuals from the hospice who provided bereavement services during the reporting period;
29. The total number of volunteers during the reporting period;
30. The total number of hours that volunteers provided hospice services during the reporting period;
31. The number of patient care days during the reporting period, for whom:
    a. The payer source was:
        i. Medicare,
        ii. AHCCCS,
        iii. Self-pay,
        iv. A private insurance company, and
        v. A payer source not specified in subsections (C)(31)(a)(i) through (C)(31)(a)(iv), and
    b. There was no payer source identified;
32. The total number of patient care days specified in subsection (C)(31);
33. The total amount of money billed, during the reporting period to:
    a. Medicare,
    b. AHCCCS,
    c. Self-pay,
    d. A private insurance company, and
    e. A payer source not specified in subsections (C)(33)(a) through (C)(33)(d);

34. The total amount of money billed during the reporting period;
35. The amount of revenue generated, for each type of revenue, by the hospice during the reporting period;
36. The amount of allowances given, for each type of allowance, by the hospice during the reporting period;
37. The total amount of revenue generated and allowances given by the hospice during the reporting period;
38. The operating expenses incurred, for each type of operating expense, by the hospice during the reporting period;
39. The total operating expenses incurred by the hospice during the reporting period;
40. The difference between the amount identified in subsection (C)(37) and the amount identified in subsection (C)(39);
41. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospice during the reporting period;
42. The amount of assets, for each type of asset, of the hospice at the end of the reporting period;
43. The total amount of assets of the hospice at the end of the reporting period;
44. The amount of liabilities, for each type of liability, of the hospice at the end of the reporting period;
45. The total amount of liabilities of the hospice at the end of the reporting period;
46. The amount of net assets, for each type of net asset, of the hospice at the end of the reporting period;
47. The total amount of net assets of the hospice at the end of the reporting period;
48. The difference between the amount identified in subsection (C)(47) and the amount identified in subsection (C)(45); and
49. The statement of cash flows required in A.R.S. § 36-125.04(C)(3).

D. A hospice administrator or designee shall:

1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the hospice administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not complete;

iii. State what actions the hospice is taking to correct the inaccurate information or make the information complete; and

iv. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospice administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospice administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. Definitions

In this Article, unless otherwise specified:

1. "Adolescent" means an individual the hospital designates as an adolescent based on the hospital's criteria.
2. "Adult" means the same as in A.A.C. R9-10-201.
3. "Behavioral health service" means the same as in A.R.S. § 36-401.
4. "Blood bank cross match" means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
5. "Complete blood count with differential" means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual's blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
6. "Contrast medium" means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
7. "CT" means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.
8. "Current rates and charges information" means the most recent rates and charges schedule for a health care institution on file with the Department, and all documents changing the most recent rates and charges schedule.
9. "Drug" means the same as in A.R.S. § 32-1901.
10. "EEG" means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.
11. "EKG" means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. "Facility" means a building and associated personnel and equipment that perform a particular service or activity.
13. "Formulary" means a list of drugs that are available to a patient through a hospital.
14. "Home health agency" means the same as in A.R.S. § 36-151.
15. "Home health agency administrator" means the chief administrative officer for a home health agency.
16. "Hospital department" means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. "Implementation date" means the month, day, and year a health care institution intends to begin

using specific rates and charges when billing a patient or resident.

18. "Intensive care bed" means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. "IVP" means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. "Labor and delivery" means services provided to a woman related to childbirth.
21. "Lithotripsy" means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. "Mark-up" means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. "MRI" means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. "Neonate" means the same as in A.A.C. R9-10-201.
25. "Nursery bed" means an available bed used to provide hospital services to a neonate.
26. "Outpatient treatment center" means the same as in A.A.C. R9-10-101.
27. "Outpatient treatment center administrator" means the chief administrative officer for an outpatient treatment center.
28. "Overview form" means a document:
    a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital's current rates and charges information, and
    b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. "Pediatric" means the same as in A.A.C. R9-10-201.
30. "Pediatric bed" means an available bed used to provide hospital services to a pediatric patient.
31. "Physical therapy" means the same as in A.R.S. § 32-2001.
32. "Post-hospital extended care services" means the services that are described in and meet the requirements of 42 CFR 409.31.
33. "Private room" means a room that contains one available bed.
34. "Rate" means a specific dollar amount per unit of service set by a health care institution.
35. "Rates and charges schedule" means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.
36. "Rehabilitation bed" means a type of bed used to provide services to a patient to restore or to optimize the patient's functional capability.

37. "Review" means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.
38. "Semi-private room" means a room that contains two available beds.
39. "Skilled nursing bed" means an available bed used for a patient requiring skilled nursing services.
40. "Skilled nursing services" means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.
41. "Small volume nebulizer" means a device that:
    a. Holds liquid medicine that is turned into a mist by an air compressor, and
    b. Is used for treatments lasting less than 20 minutes.
42. "Swing bed" means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.
43. "Swing-bed hospital" means the same as in 42 CFR 413.114.
44. "Trauma team activation" means a notification by a health care institution:
    a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;
    b. That is based on a patient's triage information; and
    c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.
45. "Ultrasound" means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.

R9-11-302. Hospital Rates and Charges Schedule

A. Before a hospital provides services to patients, a hospital administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:
    a. The name, physical address, mailing address, county, and telephone number of the hospital;
    b. The identification number assigned to the hospital:
        i. By the Department;
        ii. By AHCCCS, if applicable;
        iii. By Medicare, if applicable; and
        iv. As the hospital's national provider identifier;
    c. The name, telephone number, and e-mail address of:

i. The hospital administrator,

ii. The hospital chief financial officer, and

iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and

d. The planned implementation date for the rates and charges;

2. A rates and charges schedule prepared as specified in subsection (B); and

3. A form provided by the Department, on which the hospital administrator or designee:

a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted ac-cording to subsections (A)(1) and (B) is accurate and complete; or

b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (B) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.

B. A hospital administrator shall ensure that a rates and charges schedule:

1. Contains a table of contents for the rates and charges schedule that lists:

a. The beginning line number or page number for the hospital rates and charges overview form required in subsection (B)(2);

b. For each hospital department:

i. The hospital department's name and identification number,

ii. The beginning line number or page number of the rates and charges schedule for the hospital department, and

iii. The charge source's name and identification number for each charge source within the hospital department;

c. The beginning line number or page number for the list required in subsection (B)(4) that matches the name of each charge source with its charge source identification number;

d. The beginning line number or page number for the formula section for formulary, commodity, and contracted services mark-ups required in subsection (B)(5); and

e. The beginning line number or page number for the copy of the hospital's allowance rules and formulae required in subsection (B)(6);

2. Contains an overview form, in a format specified by the Department, that includes:

a. The hospital's name, city, and county;

b. The identification number assigned to the hospital by the Department;

c. The name, telephone number, and e-mail of the individual who prepared the overview form;

d. The date the overview form was submitted to the Department;

e. The hospital's licensed capacity;

f. Whether the entity that is the owner of the hospital is:

i. Not for profit;

ii. For profit; or

iii. A federal, state, or local government agency;

g. The hospital's classification;

h. The planned implementation date for the rates and charges in the overview form;

i. The total percent increase of the rates and charges listed in the overview form compared with the rates and charges from the last overview form, if applicable;

j. The date the overview form was last changed, if applicable;

k. The daily charge for a private room;

l. The daily charge for a semi-private room;

m. The daily charge for a pediatric bed;

n. The daily charge for a nursery bed;

o. The daily charge for a pediatric intensive care bed;

p. The daily charge for a neonatal intensive care bed;

q. The daily charge for a cardiovascular intensive care bed;

r. The daily charge for a swing bed;

s. The daily charge for a rehabilitation bed;

t. The daily charge for a skilled nursing bed;

u. The minimum charges for labor and delivery;

v. The minimum charge for trauma team activation;

w. The minimum charge for an EEG;

x. The minimum charge for an EKG;

y. The minimum charge for a complete blood count with differential;

z. The minimum charge for a blood bank crossmatch;

aa. The minimum charge for a lithotripsy;

bb. The minimum charge for an x-ray;

cc. The minimum charge for an IVP;

dd. The minimum charge for a respiratory therapy session with a small volume nebulizer;

ee. The minimum charge for a CT scan of a head without contrast medium;

ff. The minimum charge for a CT scan of an abdomen with contrast medium;

gg. The minimum charge for an abdomen ultrasound;

hh. The minimum charge for a brain MRI without contrast medium;

ii. The minimum charge for 15 minutes of physical therapy;

jj. The daily rate for behavioral health services for:

i. An adult patient,

ii. An adolescent patient, and

iii. A pediatric patient; and

kk. The code, if applicable, for the units of service specified in subsections (B)(2)(k) through (B)(2)(jj);

3. Lists for each hospital department, in a format specified by the Department:

a. The hospital department name and identification number;

b. The charge source name and identification number for each charge source within the hospital department; and

c. For each unit of service offered by the hospital for which a separate rate or charge is billed from the charge source:

i. The unit of service code;

ii. A description of the unit of service;

iii. The rate or charge for the unit of service; and

iv. The number of times a separate charge was billed for the unit of service during the previous 12 months, if applicable;

4. Contains a list that matches the name of each charge source with its charge source identification number;

5. Contains a formula section for formulary, commodity, and contracted services mark-ups; and

6. Contains a copy of the hospital's allowance rules and formulae, if applicable.

C. To change a hospital's current rates and charges information, a hospital administrator or designee shall submit to the Department:

1. A cover letter:

a. Containing the information specified in subsection (A)(1), and

b. Stating that the accompanying information is changing the hospital's current rates and charges information;

2. Either:

a. The rates and charges schedule specified in subsection (A)(2); or

b. The following information:

i. A description of:

(1) The current and new rate or charge for each unit of service undergoing a change;

(2) The name of each charge source undergoing a change and its charge source identification number;

(3) The current and new formulary, commodity, and contracted services formulae for each change in the hospital's mark-up;

(4) The current and new allowance rules and formulae for each change in the hospital's allowance rules and formulae; and

(5) How the hospital rates and charges overview form required in subsection (B)(2) is affected by the changes specified in subsections (C)(2)(b)(i)(1) through (C)(2)(b)(i)(4);

ii. The line number or page number in the hospital's current rates and charges information for each change listed in subsection (C)(2)(b)(i); and

iii. A list of each previous change:

(1) To a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula being changed;

(2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (C)(2)(a); and

(3) Including:

(a) The date the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

(b) A description of how the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

3. A form provided by the Department, on which the hospital administrator or designee:

a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted ac-cording to subsections (C)(1) and (C)(2) is accurate and complete; or

b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (C)(1) and (C)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (C)(1) and (C)(2), except the information identified in subsection (C)(3)(b)(i), is accurate and complete.

D. A hospital administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the hospital but not earlier than:

1. The date the Department notifies the hospital that the Department has completed a review of the rates and charges schedule, or
2. Sixty calendar days after the Department notifies the hospital that the Department received the rates and charges schedule.

E. A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):

1. That is:
   a. A new rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
   b. An increase in a rate or charge;
   c. A change to a formulary, commodity, or contracted services formula, which results in an increase in a rate or charge; or
   d. A change to an allowance rule or formula, which results in an increase in a rate or charge; and
2. On a date determined by the hospital, but not earlier than:
   a. The date the Department notifies the hospital that the Department has completed a review of the information submitted as specified in subsection (C), or
   b. Sixty calendar days after the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

F. A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):

1. That is:

a. A deletion of a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;

b. A reduction in a rate or charge;

c. A change to a formulary, commodity, or contracted services formula, which results in a reduction in a rate or charge; or

d. A change to an allowance rule or formula, which results in a reduction in a rate or charge; and

2. On a date:

a. Determined by the hospital, and

b. Not earlier than the date the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

G. When the Department receives from a hospital a rates and charges schedule submitted as specified in subsection (A), or a change in the hospital's current rates and charges information submitted as specified in subsection (C), the Department shall:

1. Provide written notice to the hospital within five business days of receipt of the rates and charges information, and

2. Provide written notice to the hospital within 60 calendar days that the Department has reviewed the rates and charges information.

H. A hospital administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the hospital's current rates and charges information not prepared as specified in subsection (C), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

I. If a hospital administrator or designee does not submit a rates and charges schedule or information about changes to the hospital's rates or charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-303. Nursing Care Institution Rates and Charges Schedule

A. Before a nursing care institution provides services to residents, a nursing care institution administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:

a. The name, physical address, mailing address, county, and telephone number of the nursing care institution;

b. The name, physical address, mailing address, and telephone number of the nursing care institution's:

i. Home office, if applicable; and

ii. Management company, if applicable;

c. The identification number assigned to the nursing care institution:

i. By the Department;

ii. By AHCCCS, if applicable;

iii. By Medicare, if applicable; and

iv. As the nursing care institution's national provider identifier;

d. The name, telephone number, and e-mail address of:

i. The nursing care institution administrator,

ii. The nursing care institution chief financial officer, and

iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and

e. The planned implementation date for the rates and charges;

2. A rates and charges schedule, in a format specified by the Department, containing:

a. A table of contents;

b. A description of and the rates and charges for:

i. Each type of bed; and

ii. Each unit of service, other than a type of bed, for which a separate rate or charge is billed; and

c. A copy of any nursing care institution rules or formulae which may affect the rate or charge for a type of bed or other unit of service; and

3. A form provided by the Department, on which the nursing care institution administrator or designee:

a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or

b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or de-signee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in sub-section (A)(3)(b)(i), is accurate and complete.

B. To change a nursing care institution's current rates and charges information, a nursing care institution administrator or designee shall submit to the Department:

1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the nursing care institution's current rates and charges information;
2. Either:
   a. The rates and charges schedule specified in subsection (A)(2); or
   b. The following information:
      i. A description of:
         (1) The current and new rate or charge for each type of bed or other unit of service undergoing a change, and
         (2) The current and new rules and formulae for each change to the nursing care institution rules or formulae that may affect the rate or charge for a type of bed or other unit of service;
      ii. The line number or page number in the nursing care institution's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
      iii. A list of each previous change:
         (1) To a rate, charge, rule, or formula being changed;
         (2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (B)(2)(a); and
         (3) Including:
            (a) The date the rate, charge, rule, or formula was previously changed; and
            (b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the nursing care institution administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or
   b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or de-signee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in sub-section (B)(3)(b)(i), is accurate and complete.

C. A nursing care institution administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the nursing care institution but not earlier than:
1. The date the Department notifies the nursing care institution that the Department has completed a review of the rates and charges schedule, or
2. Sixty calendar days after the Department notifies the nursing care institution that the Department received the rates and charges schedule.

D. A nursing care institution administrator shall implement a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B):
1. That is:
   a. A new rate, charge, rule, or formula;
   b. An increase in a rate or charge; or
   c. A change to a rule or formula, which results in an increase in a rate or charge; and
2. On a date determined by the nursing care institution, but not earlier than:
   a. The date the Department notifies the nursing care institution that the Department has completed a review of the information submitted as specified in subsection (B), or
   b. Sixty calendar days after the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).

E. A nursing care institution administrator shall implement a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B):

1. That is:
   a. A deletion of rate or charge;
   b. A reduction in a rate or charge; or
   c. A change to a rule or formula, which results in a reduction in a rate or charge; and
2. On a date:
   a. Determined by the nursing care institution, and
   b. Not earlier than the date the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).

F. When the Department receives from a nursing care institution a rates and charges schedule submitted as specified in subsection (A), or a change in the nursing care institution's current rates and charges information submitted as specified in subsection (B), the Department shall:

1. Provide written notice to the nursing care institution within five business days of receipt of the rates and charges information, and
2. Provide written notice to the nursing care institution within 60 calendar days that the Department has reviewed the rates and charges information.

G. A nursing care institution administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the nursing care institution's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

H. If a nursing care institution administrator or designee does not submit a rates and charges schedule or information about changes to the nursing care institution's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-304. Home Health Agency Rates and Charges Schedule

A. Before a home health agency provides services to patients, a home health agency administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:

a. The name, physical address, mailing address, county, and telephone number of the home health agency;

b. The identification number assigned to the home health agency:

i. By the Department;

ii. By AHCCCS, if applicable;

iii By Medicare, if applicable; and

iv. As the home health agency's national provider identifier;

c. The name, telephone number, and e-mail address of:

i. The home health agency administrator,

ii. The home health agency chief financial officer, and

iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and

d. The planned implementation date for the rates and charges;

2. Either:

a. A rates and charges schedule, in a format specified by the Department, containing:

i. A table of contents;

ii. For each unit of service offered for which a separate rate or charge is billed:

(1) The unit of service code,

(2) A description of the unit of service, and

(3) The rate or charge for the unit of service; and

iii. A copy of any home health agency rules or formulae that may affect the rate or charge for a unit of service; or

b. Current cost reports and financial information that the home health agency files for other government reporting purposes if the current cost reports and financial information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and

3. A form provided by the Department, on which the home health agency administrator or designee:

a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or

b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the home health agency is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.

B. To change a home health agency's current rates and charges information, a home health agency administrator or designee shall submit to the Department:

1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the home health agency's current rates and charges information;
2. Either:
   a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
   b. The following information:
      i. A description of:
         (1) The current and new rate or charge for each unit of service undergoing a change, and
         (2) The current and new rules and formulae for each change to the home health agency rules or formulae which may affect the rate or charge for a unit of service;
      ii. The line number or page number in the home health agency's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
      iii. A list of each previous change:
         (1) To a rate, charge, rule, or formula being changed;
         (2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and
         (3) Including:
            (a) The date the rate, charge, rule, or formula was previously changed; and

(b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the home health agency administrator or designee:

a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or

b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the home health agency is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. A home health agency administrator shall implement rates and charges for a rates and charges schedule submitted as specified in sub-section (A) or for a change in the home health agency's current rates and charges information submitted as specified in subsection (B) on a date determined by the home health agency but not earlier than the date the Department notifies the home health agency that the Department received the rates and charges information.

D. When the Department receives from a home health agency a rates and charges schedule submitted as specified in subsection (A) or a change in the home health agency's current rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the home health agency within five business days of receipt of the rates and charges information.

E. A home health agency administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the home health agency's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a home health agency administrator or designee does not submit a rates and charges schedule or information about changes to the home health agency's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

R9-11-305. Outpatient Treatment Center Rates and Charges Schedule

A. Before an outpatient treatment center provides services to patients, an outpatient treatment center administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:
   a. The name, physical address, mailing address, county, and telephone number of the outpatient treatment center;
   b. The identification number assigned to the outpatient treatment center:
      i. By the Department;
      ii. By AHCCCS, if applicable;
      iii. By Medicare, if applicable; and
      iv. As the outpatient treatment center's national provider identifier;
   c. The name, telephone number, and e-mail address of:
      i. The outpatient treatment center administrator,
      ii. The outpatient treatment center chief financial officer, and
      iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
   d. The planned implementation date for the rates and charges;
2. Either:
   a. A rates and charges schedule, in a format specified by the Department, containing:
      i. A table of contents;
      ii. For each unit of service offered for which a separate rate or charge is billed:
         (1) The unit of service code,
         (2) A description of the unit of service, and
         (3) The rate or charge for the unit of service; and
      iii. A copy of any outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service; or
   b. Current cost reports and financial information that the outpatient treatment center files for other government reporting purposes if the current cost reports and financial

information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and

3. A form provided by the Department, on which the outpatient treatment center administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
   b. If the outpatient treatment center administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the outpatient treatment center is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.

B. To change an outpatient treatment center's current rates and charges information, an outpatient treatment center administrator or designee shall submit to the Department:

1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the outpatient treatment center's current rates and charges information;
2. Either:
   a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
   b. The following information:
      i. A description of:
         (1) The current and new rate or charge for each unit of service undergoing a change, and
         (2) The current and new rules and formulae for each change to the outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service;

ii. The line number or page number in the outpatient treatment center's current rates and charges information for each change listed in subsection (B)(2)(b)(i); and

iii. A list of each previous change:

(1) To a rate, charge, rule, or formula being changed;

(2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and

(3) Including:

(a) The date the rate, charge, rule, or formula was previously changed; and

(b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the outpatient treatment center administrator or designee:

a. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or

b. If the outpatient treatment center administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the outpatient treatment center is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. An outpatient treatment center administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the outpatient treatment center's current rates and charges information submitted as specified in subsection (B) on a date determined by the outpatient treatment center but not earlier than the date the Department notifies the outpatient treatment center that the Department received the rates and charges information.

D. When the Department receives from an outpatient treatment center a rates and charges schedule submitted as specified in subsection (A) or a change in the outpatient treatment center's rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the outpatient treatment center within five business days of receipt of the rates and charges information.

E. An outpatient treatment center administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the outpatient treatment center's current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If an outpatient treatment center administrator or designee does not submit a rates and charges schedule or information about changes to the outpatient treatment center's rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING

R9-11-401. Definitions

In this Article, unless otherwise specified:

1. "Admitting diagnosis" means the reason an individual is admitted to a hospital.
2. "DRG" means Diagnosis Related Group, a type of prospective payment system used in billing for inpatient episodes of care.
3. "HIPPS" means the Health Insurance Prospective Payment System, a type of prospective payment system used by specific health care institutions, such as rehabilitation hospitals, for billing for services provided by the health care institutions.
4. "Inpatient discharge report" means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-402.
5. "Length of stay" means the total number of calendar days for a specific episode of care, from the date of admission to the date of discharge.

R9-11-402. Reporting Requirements

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department with the inpatient discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital's Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the inpatient discharge report;
4. If the entity submitting the inpatient discharge report to the Department is different from the hospital:
    a. The name of the entity submitting the inpatient discharge report to the Department; and
    b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the inpatient discharge report;
5. The reporting period; and
6. The name of the electronic file containing the inpatient discharge report specified in subsection (C).

B. A hospital administrator or designee shall on a form provided by the Department:

1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
2. If the hospital administrator or designee has personal knowledge that the information submitted

according to subsection (C) is not accurate or not complete:

a. Identify the information that is not accurate or not complete;

b. Describe the circumstances that make the information not accurate or not complete;

c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and

d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.

C. A hospital administrator shall ensure that an inpatient discharge report:

1. Is prepared and named in a format specified by the Department;

2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and

3. Contains the following information for each inpatient discharge that occurred during the reporting period specified in subsection (A)(5):

a. The Arizona facility ID and national provider identifier for the hospital;

b. A code indicating that the information submitted about the patient is for an inpatient episode of care;

c. The patient's medical record number;

d. The patient's control number;

e. The patient's name;

f. The patient's mailing address;

g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;

h. A code indicating that the patient is homeless, if applicable;

i. The patient's date of birth and last four digits of the patient's Social Security number;

j. Codes indicating the patient's gender, race, ethnicity, and marital status;

k. The date and a code indicating the hour the patient was admitted to the hospital;

l. A code indicating the priority of visit;

m. A code indicating the referral source;

n. The date and a code indicating the hour the patient was discharged from the hospital;

o. A code indicating the patient's discharge status;

p. If the patient is a newborn, the patient's birth weight in grams;

q. Whether the patient has a DNR known to the hospital;

r. The date the bill for hospital services was created;

s. The total charges billed for the episode of care;

t. A code indicating the expected payer source;

u. For each unit of service billed for the episode of care, the:

i. Revenue code;

ii. Charge billed; and

iii. HIPPS code, if applicable;

v. The DRG code for the episode of care;

w. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;

x. The International Classification of Diseases codes for the patient's admitting, principal, and secondary diagnoses;

y. If applicable, the external cause of injury codes or location of injury codes associated with the episode of care;

z. If applicable, the state in which an accident leading to the episode of care occurred;

aa. If applicable, the date of the onset of symptoms leading to the episode of care;

bb. If a procedure was performed during the episode of care:

i. The International Classification of Diseases codes for the principal procedure and any other procedures performed during the episode of care, and

ii. The dates the principal procedure and any other procedures were performed;

cc. The name, state license number, and, if applicable, national provider identifier of the patient's attending provider;

dd. The code for the state licensing board that issued the license for the patient's attending provider;

ee. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable;

ff. The code for the state licensing board that issued the license for the medical practitioner who performed the patient's principal procedure, if applicable;

gg. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient's episode of care; and

hh. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(gg).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department at least twice each calendar year, according to the following schedule:

1. For initial electronic submission of reports for individual inpatient discharges on a real-time basis, within 48 hours after the discharge; and

2. For bulk submission of inpatient discharges or completion of an electronic submission:
   a. For each inpatient discharge between January 1 and June 30, the reports, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
   b. For each inpatient discharge between July 1 and December 31, the reports, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of a report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

ARTICLE 5. EMERGENCY DEPARTMENT DISCHARGE REPORTING

R9-11-501. Definitions

In this Article, unless otherwise specified:

1. "CPT code" means a code from Current Procedural Terminology, a HCPCS coding system used primarily to identify medical services and procedures provided by medical practitioners.
2. "Emergency department discharge report" means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-502.
3. "HCPCS" means the Healthcare Common Procedure Coding System used by a hospital for billing for hospital services or commodities provided to an outpatient as defined in A.A.C. R9-10-201.

R9-11-502. Reporting Requirements

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department as part of the emergency department discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital's Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the emergency department discharge report;
4. If the entity submitting the emergency department discharge report to the Department is different from the hospital:
    a. The name of the entity submitting the emergency department discharge report to the Department; and
    b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the emergency department discharge report;
5. The reporting period; and
6. The name of the electronic file containing the emergency department discharge report specified in subsection (C).

B. A hospital administrator or designee shall on a form provided by the Department:

1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
2. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
    a. Identify the information that is not accurate or not complete;

b. Describe the circumstances that make the information not accurate or not complete;

c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and

d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.

C. A hospital administrator shall ensure that an emergency department discharge report:

1. Is prepared and named in a format specified by the Department;
2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
3. Contains the following information for each emergency department discharge that occurred during the reporting period specified in subsection (A)(5):
   a. The Arizona facility ID and national provider identifier for the hospital;
   b. A code indicating that the information submitted about the patient is for an emergency department episode of care;
   c. The patient's medical record number;
   d. The patient's control number;
   e. The patient's name;
   f. The patient's mailing address;
   g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
   h. A code indicating that the patient is homeless, if applicable;
   i. The patient's date of birth and last four digits of the patient's Social Security number;
   j. Codes indicating the patient's gender, race, ethnicity, and marital status;
   k. The date and a code indicating the hour the episode of care began;
   l. A code indicating the priority of visit;
   m. A code indicating the referral source;
   n. The date and a code indicating the hour the patient was discharged from the emergency department;
   o. A code indicating the patient's discharge status;
   p. Whether the patient has a DNR known to the hospital;
   q. The date the patient's bill was created;
   r. The total charges billed for the episode of care;
   s. A code indicating the expected payer source;
   t. For each unit of service billed for the episode of care, the:

i. Revenue code;

ii. Charge billed; and

iii. HCPCS code, if applicable;

u. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;

v. The International Classification of Diseases code designating the reason for the patient initiating the episode of care;

w. The International Classification of Diseases codes for the patient's principal and, if applicable, secondary diagnoses;

x. If applicable, the external cause of injury codes or location of injury codes associated with the episode of care;

y. If applicable, the state in which an accident leading to the episode of care occurred;

z. If applicable, the date of the onset of symptoms leading to the episode of care;

aa. For each procedure performed during the episode of care:

i. The applicable International Classification of Diseases, HCPCS/CPT codes for the principal procedure and any other procedures performed during the episode of care; and

ii. The dates the principal procedure and any other procedures were performed;

bb. The name, state license number, and, if applicable, national provider identifier of the patient's attending provider;

cc. The code for the state licensing board that issued the license for the patient's attending provider;

dd. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable;

ee. The code for the state licensing board that issued the license for the medical practitioner who performed the patient's principal procedure, if applicable;

ff. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient's episode of care; and

gg. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(ff).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department at least twice each calendar year, according to the following schedule:

1. For initial electronic submission of reports for individual emergency department discharges on a real-time basis, within 48 hours after the discharge; and

2. For bulk submission of emergency department discharges or completion of an electronic submission:
   a. For each emergency department discharge between January 1 and June 30, the report, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
   b. For each emergency department discharge between July 1 and December 31, the report, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of an emergency department discharge report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

ARTICLE 6. HEALTH PROFESSIONALS WORKFORCE DATABASE

R9-11-601. Definitions

In addition to the definitions in A.R.S. § 32-3249 and R9-11-101, the following definitions apply in this Article unless otherwise specified:

1. "Direct patient care" means the same as in A.A.C. R9-15-101.
2. "Primary practice location" means the facility in which an individual provides direct patient care for the majority of time during a year.

R9-11-602. Designated Database Information

A. A Board shall establish a process for requesting the information in subsection (B):

1. From an individual applying for an initial license, certification, or registration, at the time of application; and
2. From an individual regulated by the Board, in compliance with A.R.S. § 32-3249.01(A).

B. A Board shall request the following information about an individual, in a Department-provided format:

1. The individual's name;
2. The individual's date of birth;
3. The individual's gender;
4. The individual's race and ethnicity;
5. If applicable, the individual's National Provider Number;
6. Whether the individual is able to provide services to patients or clients in a language other than English and, if so, in which languages;
7. The type of license, certification, or registration held by the individual or for which the individual is applying;
8. The individual's professional license, registration, or certification number, if applicable;
9. The beginning and end date of the individual's current license, certification, or registration, if applicable;
10. The individual's highest level of training or education related to the individual's license, certification, or registration;
11. The individual's highest level of education in another field;
12. The individual's current employment status;
13. Whether the individual is currently providing direct patient care related to the individual's license, certification, or registration, as applicable, on a regular basis in Arizona and, if so:
    a. The zip code of the individual's primary practice location;
    b. The type of facility in which the individual is providing direct patient care at the

primary practice location;

c. The number of weeks worked over the previous 12 months at the primary practice location;

d. The average hours worked per week at the primary practice location, including the percentage of time spent in:

i. Direct patient care;

ii. Administration, including any paperwork not part of direct patient care;

iii. Research;

iv. Teaching or education; or

v. Other specified activities;

e. Whether the individual expects a change in subsection (B)(13)(b), (c), or (d) in the next 12 months; and

f. If the individual expects to reduce the time spent providing direct patient care in the next 12 months, the reason for the change; and

14. If the individual is a physician, physician assistant, or registered nurse practitioner, whether the individual provides primary care services, as defined in A.A.C. R9-24-201.

R9-11-603. Transfer of Data from a Board

A. A Board shall transfer the designated database information collected according to R9-11-602 to the Department:

1. Within 60 calendar days after the effective date of this Section and on or before April 30 each year thereafter;
2. In a secure format specified by the Department and agreed to by the Board and the Department, based on the capabilities and limitations of the Board's data system that is used for storing the collected designated database information; and
3. Without the Board needing to change the format of the designated database information in the Board's data system.

B. For an initial transfer of designated database information each year, a Board shall transfer to the Department:

1. The designated database information specified in R9-11-602(B) that is already collected by the Board as part of the Board's licensing, certification, or registration process; and
2. Any other collected designated database information specified in R9-11-602, even if the information is incomplete.

C. The Department shall:

1. Review the designated database information transmitted by each Board according to subsection

(B) for completeness and consistency with the designated database information specified in R9-11-602(B)(1) through (13) and, if applicable, R9-11-602(B)(14);

2, Notify each Board of:

a. Inconsistencies with the designated database information specified in R9-11-602(B)(1) through (14), and

b. Incomplete information about individuals regulated by the Board;

3. Compile the designated database information transmitted by each Board into a single data set, stored in the health care professionals workforce data repository specified in A.R.S. § 36-171(A); and

4. Post the availability of designated database information on the Department's website.

D. Based on the information provided by the Department according to subsection (C)(2), a Board shall each year:

1. Review the process established by the Board according to R9-11-602(A), and

2. Make changes to the process that improve the consistency and completeness of the designated database information that will be transferred to the Department in the subsequent year.

R9-11-604. Requests for Release of Designated Database Information and Reports

A. Designated database information is confidential, subject to the disclosure provisions of A.R.S. § 32-3249.01(B) and (C) and 9 A.A.C. 1, Article 3.

B. The Department:

1. Shall release designated database information in an annual data set;

2. May release designated database information in a customized data set; and

3. May release reports summarizing the designated database information, based upon information requested.

C. A person may request the release of designated database information by submitting to the Department:

1. A written request, in a Department-provided format, that includes:

a. The name, mailing address, email address, and telephone number of the person submitting the request;

b. If applicable, the name, title, email address, and telephone number of an individual from an organization specified according to subsection (C)(1)(a);

c. The address to which released designated database information is to be sent;

d. In which of the Department-specified, secure formats the person is requesting the released designated database information to be sent;

e. If requesting the release of designated database information in a customized data set according to subsection (B)(2), the specific designated database information being

requested, including:

i. The specific Board or Boards,

ii. The time period for the requested designated database information, and

iii. Any other descriptors for the requested designated database information;

f. The reason the person is requesting the release of designated database information;

g. A description of the methods to be used by the person to ensure the privacy and security of released designated database information;

h. Attestations that the person requesting the release of designated database information:

i. Shall not use or disclose any portion of the released designated database information for any purpose other than a purpose specified according to subsection (C)(1)(f);

ii. Shall safeguard the released designated database information from unauthorized access, including ensuring that the designated database information is not re-released to another person;

iii. Shall not attempt to reidentify or contact individuals based on released designated database information;

iv. Shall notify the Department upon learning the identity of an individual in the released designated database information;

v. Understands that failure to ensure the privacy and security of released designated database information may result in denial of future releases of designated database information;

vi. Understands that the Department retains ownership of the released designated database information;

vii. Shall retain designated database information for a period of no more than five years from the date of release; and

viii. Shall submit a certificate of destruction, in a Department-provided format, to the Department upon destruction of the released designated database information; and

i. The dated signature of the individual specified according to subsection (C)(1)(b); and

2. Either:

a. A fee of $100 for the release of designated database information in an annual data set, or

b. A fee that covers the costs of the Department in producing and releasing designated database information in a customized data set.

D. A person may request the release of a report summarizing the designated database information or

specific portions of the designated database information by submitting to the Department:

1. A written request, in a Department-provided format, that includes:
   a. The name, mailing address, email address, and telephone number of the person submitting the request;
   b. If applicable, the name, title, email address, and telephone number of an individual from an organization specified according to subsection (C)(1)(a);
   c. The address to which the released report is to be sent;
   d. The specific designated database information to be included in the summarized report, including:
      i. The specific Board or Boards,
      ii. The time period of the requested designated database information, and
      iii. Any other descriptors of the requested designated database information; and
   e. The dated signature of the individual specified according to subsection (D)(1)(b); and
2. A fee that covers the costs of the Department in producing and releasing the report.