

Title 388 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF

- 388-845 **DDD home and community based services waivers.**
- 388-865 **Community mental health and involuntary treatment programs.**
- 388-891 **Vocational rehabilitation services for individuals with disabilities.**

DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

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| 388-890-1035 | What are IL preventative services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1035, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. | 388-890-1085 | If the IL program decides I am not eligible for IL program services, is the decision reviewed? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1085, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. |
| 388-890-1040 | What are IL recreational services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1040, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. | 388-890-1090 | Does the IL program keep a record of my IL program services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1090, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. |
| 388-890-1045 | What are IL program services to family members? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1045, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. | 388-890-1095 | Does the IL program keep personal information confidential? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1095, filed 8/27/99, effective 11/1/99.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. |
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Chapter 388-14A WAC

DIVISION OF CHILD SUPPORT RULES

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WAC 388-14A-2105 Basic confidentiality rules for the division of child support. (1) Under RCW 26.23.120, all information and records, concerning persons who owe a support obligation or for whom the division of child support (DCS) provides support enforcement services, are private and confidential.

(2) DCS discloses information and records only to a person or entity listed in this section or in RCW 26.23.120, and only for a specific purpose allowed by state or federal law. See WAC 388-14A-7500 regarding disclosure of personal information in the context of referrals under the Uniform Interstate Family Support Act (UIFSA).

(3) DCS may disclose information to:

(a) The person who is the subject of the information or records, unless the information or records are exempt under RCW 42.17.310;

(b) Local, state, and federal government agencies for support enforcement and related purposes;

(c) A party to a judicial proceeding or a hearing under chapter 34.05 RCW, if the superior court judge or administrative law judge (ALJ) enters an order to disclose. The judge or presiding officer must base the order on a written finding that the need for the information outweighs any reason for maintaining privacy and confidentiality;

(d) A party under contract with DCS, including a federally recognized Indian tribe, if disclosure is for support enforcement and related purposes;

(e) A person or entity, including a federally recognized Indian tribe, when disclosure is necessary to the administration of the child support program or the performance of DCS functions and duties under state and federal law;

(f) A person, representative, or entity if the person who is the subject of the information and records consents, in writing, to disclosure;

(g) The office of administrative hearings or the office of appeals for administration of the hearing process under chapter 34.05 RCW. The ALJ or review judge must:

(i) Not include the address of either party in an administrative order, or disclose a party's address to the other party;

(ii) State in support orders that the address is known by the Washington state support registry; and

(iii) Inform the parties they may obtain the address by submitting a request for disclosure to DCS under WAC 388-14A-2110(2).

(4) DCS may publish information about a noncustodial parent (NCP) for locate and enforcement purposes.

(5) WAC 388-14A-2114(1) sets out the rules for disclosure of address, employment or other information regarding the custodial parent (CP) or the children in response to a public disclosure request.

(6) WAC 388-14A-2114(2) sets out the rules for disclosure of address, employment or other information regarding the NCP in response to a public disclosure request.

(7) DCS may disclose the Social Security Number of a dependent child to the noncustodial parent (NCP) to enable the NCP to claim the dependency exemption as authorized by the Internal Revenue Service.

(8) DCS may disclose financial records of an individual obtained from a financial institution only for the purpose of, and to the extent necessary, to establish, modify, or enforce a child support obligation of that individual.

(9) Except as provided elsewhere in chapter 388-14A WAC, chapter 388-01 WAC governs the process of requesting and disclosing information and records.

(10) DCS must take timely action on requests for disclosure. DCS must respond in writing within five working days of receipt of the request.

(11) If a child is receiving foster care services, the parent(s) must contact their local community services office for disclosure of the child's address information.

(12) The rules of confidentiality and penalties for misuse of information and reports that apply to a IV-D agency employee, also apply to a person who receives information under this section.

(13) Nothing in these rules:

(a) Prevents DCS from disclosing information and records when such disclosure is necessary to the performance of its duties and functions as provided by state and federal law;

(b) Requires DCS to disclose information and records obtained from a confidential source.

(14) DCS cannot provide copies of the confidential information form contained in court orders. You must go to court to get access to the confidential information form. DCS may disclose information contained within the confidential information form if disclosure is authorized under RCW 26.23.120, chapter 388-01 WAC, or chapter 388-14A WAC.

(15) DCS may provide a Support Order Summary to the parties to an administrative support order under WAC 388-14A-2116.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-2105, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 26.23.120, 74.08.090, 02-07-091, § 388-14A-2105, filed 3/19/02, effective 4/19/02; 01-03-089, § 388-14A-2105, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-030.]

WAC 388-14A-3200 How does DCS determine my support obligation? (1) The division of child support (DCS) determines support obligations using the Washington state child support schedule (the WSCSS), which is found in chapter 26.19 RCW, for the establishment and modification of support orders.

(2) See WAC 388-14A-8100 for rules on completing the worksheets under the WSCSS for cases where DCS is determining support for a child in foster care.

(3) DCS does not have statutory authority to set the child support obligations of both the noncustodial parent (NCP) and custodial parent (CP) in the same administrative proceeding.

(a) DCS orders can not set off the support obligation of one parent against the other.

(b) Therefore, the method set forth in *Marriage of Arvey*, 77 Wn. App 817, 894 P.2d 1346 (1995), must not be applied when DCS determines a support obligation.

(4) The limitations in this section apply to DCS staff and to administrative law judges (ALJs) who are setting child support obligations.

[Statutory Authority: RCW 74.08.090, 34.05.220 (1)(a), 74.20A.055, 07-06-053, § 388-14A-3200, filed 3/2/07, effective 4/2/07. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056, 06-16-073, § 388-14A-3200, filed 7/28/06, effective 8/28/06; 00-15-016 and 00-20-022, § 388-14A-3200, filed 7/10/00 and 9/25/00, effective 11/6/00. Formerly WAC 388-11-205.]

WAC 388-14A-3304 The division of child support may serve a notice of support debt and demand for payment when it is enforcing a support order issued in Washington state, a foreign court order or a foreign administrative order for support. (1) The division of child support (DCS) may serve a notice of support debt and demand for payment on a noncustodial parent (NCP) under RCW 74.20A.040 to provide notice that DCS is enforcing a support order entered in Washington state, a foreign court order or a foreign administrative order for support.

(a) A "foreign" order is one entered in a jurisdiction other than a Washington state court or administrative forum.

(b) DCS uses the notice of support debt and demand for payment when there is only one current child support order for the NCP and the children in the case.

(c) When there are multiple current support orders for the same obligor and children, DCS determines which order to enforce as provided under WAC 388-14A-3307.

(2) DCS serves a notice of support debt and demand for payment like a summons in a civil action or by certified mail, return receipt requested.

(3) In a notice of support debt and demand for payment, DCS includes the information required by RCW 74.20A.040, the amount of current and future support, accrued support debt, interest (if interest is being assessed under WAC 388-14A-7110), any health insurance coverage obligation, and any day care costs under the court or administrative order.

(4) After service of a notice of support debt and demand for payment, the NCP must make all support payments to the Washington state support registry. DCS does not credit payments made to any other party after service of a notice of support debt and demand for payment except as provided in WAC 388-14A-3375.

(5) A notice of support debt and demand for payment becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW, subject to the terms of the order, unless, within twenty days of service of the notice in Washington, the NCP:

(a) Files a request with DCS for a conference board under WAC 388-14A-6400. The effective date of a conference board request is the date DCS receives the request;

(b) Obtains a stay from the superior court; or

(c) Objects to either the validity of the foreign support order or the administrative enforcement of the foreign support order, in which case DCS proceeds with registration of the foreign support order under WAC 388-14A-7100.

(6) A notice of support debt and demand for payment served in another state becomes final according to WAC 388-14A-7200.

(7) Enforcement of the following are not stayed by a request for a conference board or hearing under this section or WAC 388-14A-6400:

(a) Current and future support stated in the order; and

(b) Any portion of the support debt that the NCP and custodial parent (CP) fail to claim is not owed.

(8) Following service of the notice of support debt and demand for payment on the NCP, DCS mails to the last known address of the CP and/or the payee under the order:

(a) A copy of the notice of support debt and demand for payment; and

(b) A notice to payee under WAC 388-14A-3315 regarding the payee's rights to contest the notice of support debt. The CP who is not the payee under the order has the same rights to contest the notice of support debt and demand for payment.

(9) If the NCP requests a conference board under subsection (5)(a) of this section, DCS mails a copy of the notice of conference board to the CP informing the CP of the CP's right to:

(a) Participate in the conference board; or

(b) Request a hearing under WAC 388-14A-3321 within twenty days of the date of a notice of conference board that was mailed to a Washington address. If the notice of conference board was mailed to an out-of-state address, the CP may request a hearing within sixty days of the date of the notice of conference board. The effective date of a hearing request is the date DCS receives the request.

(10) If the CP requests a hearing under subsection (9) of this section, DCS must:

(a) Stay enforcement of the notice of support debt and demand for payment except as required under subsection (6) of this section; and

(b) Notify the NCP of the hearing.

(11) If a CP requests a late hearing under subsection (8) of this section, the CP must show good cause for filing the late request.

(12) The NCP is limited to a conference board to contest the notice and may not request a hearing on a notice of support debt and demand for payment. However, if the CP requests a hearing, the NCP may participate in the hearing.

(13) A notice of support debt and demand for payment must fully and fairly inform the NCP of the rights and responsibilities in this section.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-3304, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 26.21.016, 74.08.090, 26.23.-035, 34.05.220(1), 74.20A.310, 26.23.110, and 74.20A.040, 05-07-059, § 388-14A-3304, filed 3/11/05, effective 4/11/05. Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.310, 01-03-089, § 388-14A-3304, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-435.]

WAC 388-14A-3305 What can I do if I disagree with a notice of support debt and demand for payment? Once the division of child support has served a notice of support debt and demand for payment, either party may disagree with the notice.

(1) If either party objects to the enforcement of a non-Washington support order, that party may request that DCS register that order under chapter 26.21A RCW. DCS then serves a notice of support debt and registration as provided in WAC 388-14A-7110.

(2) If the noncustodial parent (NCP) objects to the amount of current support or the amount of support debt stated in the notice, the NCP may request a conference board under WAC 388-14A-6400.

(a) The custodial parent (CP) may participate in the conference board under this section.

(b) The CP may choose to convert the proceeding to an administrative hearing. The NCP may participate in a hearing held under this section.

(3) If the custodial parent objects to the amount of current support or the amount of support debt stated in the notice, the CP may request an administrative hearing. The NCP may participate in a hearing held under this section.

(4) See WAC 388-14A-3304 for a more full description of the hearing process on the notice of support debt and demand for payment.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-3305, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-3306 Does a notice of support debt and demand for payment result in a final determination of support arrears? (1) After service of a notice of support debt and demand for payment as provided in WAC 388-14A-3304, the final administrative order determines the support debt as of the date of the order, and:

(a) The debt determination is not a final determination under the Uniform Interstate Family Support Act (UIFSA), chapter 26.21A RCW.

(b) Any party may request that a tribunal determine any amounts owed as interest on the support debt.

(2) The final administrative order comes about by:

(a) Operation of law if nobody objects to the notice;

(b) Agreed settlement or consent order under WAC 388-14A-3600;

(c) Final conference board decision under WAC 388-14A-6400;

(d) Final administrative order entered after hearing or a party's failure to appear for hearing.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-3306, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-3307 How does the division of child support proceed when there are multiple child support orders for the same obligor and children? When more than one current child support order exists for the same obligor and children, the division of child support (DCS) may proceed as follows:

(1) Using the criteria listed in RCW 26.21A.130, DCS decides which child support order it should enforce and serves a notice of support debt and demand for payment under WAC 388-14A-3304.

(2) If DCS decides that a determination of controlling order under chapter 26.21A RCW is required, DCS serves a notice of support debt and registration as provided in WAC 388-14A-7100.

(3) Upon request, DCS may do a determination of controlling order (DCO).

(a) See WAC 388-14A-7305 for how you can ask for a DCO.

(b) See WAC 388-14A-7315 for how DCS decides whether or not to do a DCO.

(4) If DCS does a DCO and decides that a Washington order is the controlling order, DCS refers the case to superior court.

(5) If DCS does a DCO and decides that a non-Washington order is the controlling order, DCS serves a notice of support debt and registration as provided in WAC 388-14A-7325.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-3307, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-3925 Who can ask to modify an administrative support order? (1) The division of child support (DCS), the custodial parent (CP) or the noncustodial parent (NCP) may request a hearing to prospectively modify the NCP's obligation under a support establishment notice. The request must be in writing and must state:

(a) Any circumstances that have changed; and

(b) The proposed new support amount.

(2) The petitioning party must file the request for modification with DCS.

(3) DCS serves a copy of the request for modification and notice of hearing on all other parties by first class mail at their address last known to DCS.

(4) DCS, the administrative law judge (ALJ), or the department review judge:

(a) Prospectively modifies orders according to the terms of chapter 26.19 RCW and RCW 74.20A.059; and

(b) May only modify an order issued by a tribunal in another state according to the terms of RCW 26.21A.550.

(5) If the nonpetitioning party fails to appear at the hearing, the ALJ issues a default order based on the Washington state child support schedule and the worksheets submitted by the parties, considering the terms set out in the request for modification.

(6) If the petitioning party fails to appear at the hearing, the ALJ enters an order dismissing the petition for modification.

(7) If the petition for modification does not comply with the requirements of subsection (1)(a) and (b) of this section, the ALJ may:

(a) Dismiss the petition; or

(b) Continue the hearing to give the petitioning party time to amend according to WAC 388-14A-3275 or to complete the petition.

(8) The ALJ may set the effective date of modification as the date the order is issued, the date the request was made, or any time in between. If an effective date is not set in the order, the effective date is the date the modification order is entered.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-3925, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056. 02-06-098, § 388-14A-3925, filed 3/4/02, effective 4/4/02. Statutory Authority: RCW 74.08.090, 26.23.050, 74.20A.055, 74.20A.059. 01-03-089, § 388-14A-3925, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-140.]

WAC 388-14A-5300 How does the division of child support recover a support payment which has already been distributed? (1) The division of child support (DCS) may serve a notice to recover a support payment on the person who received the payment when DCS:

(a) Distributed the money in error;

(b) Distributed the money based on a check that is later dishonored;

(c) Is required to refund or return the money to the person or entity that made the payment; or

(d) Distributed money under a support order that was later modified so as to create an overpayment.

(2) DCS serves a notice to recover a support payment like a summons in a civil action or by certified mail, return receipt requested.

(3) In the notice, DCS must identify the support payment DCS seeks to recover.

(4) DCS may take action to enforce the notice to recover a support payment without further notice once the notice becomes final.

(a) A notice to recover a support payment becomes final unless the person who received the payment requests a hearing under subsection (5) of this section within twenty days of service of the notice to recover a support payment in Washington. The effective date of a hearing request is the date DCS receives the request.

(b) A notice to recover a support payment may be served in another state to recover a payment disbursed by DCS under RCW 26.21A.290. A notice to recover a support payment served in another state becomes final according to WAC 388-14A-7200.

(5) A hearing on a notice to recover a support payment is for the limited purpose of resolving the existence and amount of the debt DCS is entitled to recover.

(6) A person who files a late request for a hearing on a notice to recover a support payment must show good cause for being late.

(7) In nonassistance cases and payment services only cases, DCS may recover a support payment under a final administrative order on a notice to recover a support payment by retaining ten percent of current support and one hundred percent of amounts collected on arrears in addition to any other remedy authorized by law.

(8) If a public assistance recipient receives a support payment directly from a noncustodial parent (NCP) and fails

to remit it to DCS as required, DCS recovers the money as retained support under WAC 388-14A-5500.

(9) DCS may enforce the notice to recover a support payment as provided in subsection (7), or may act according to RCW 74.20A.270 as deemed appropriate.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-5300, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-272.]

WAC 388-14A-6100 The division of child support accepts oral requests for hearing or conference board. (1) Except for the instances listed in subsections (8) and (9), the division of child support (DCS) accepts either a written or an oral request for hearing or conference board, even though other sections of this chapter or the relevant statutes may provide that objections and hearing requests should be in writing.

(2) The subject matter of the objection determines whether the matter is set as a conference board or hearing, unless there is a specific request for an administrative hearing under chapter 34.05 RCW.

(3) DCS processes oral and written requests for hearing in the same manner.

(4) An oral request for hearing is complete if it contains enough information to identify the person making the request, the DCS action, and the case or cases involved in the hearing request.

(5) The effective date of an oral request for hearing is the date that someone makes a complete oral request for hearing, to any DCS representative in person or by leaving a message on the automated voice mail system of any DCS field office.

(6) When making an oral request, you do not need to specify whether you want a hearing under chapter 34.05 RCW or a conference board under WAC 388-14A-6400.

(7) You can make an oral request for hearing or conference board on behalf of another person, if you have written authorization to act on their behalf. The effective date of an oral request for hearing or conference board made on behalf of another person is the later of the date of the complete oral request for hearing or the date that DCS receives the written authorization.

(8) There are two types of hearing requests which must be in writing:

(a) A petition for prospective modification under WAC 388-14A-3925; and

(b) A petition for reimbursement for day care expenses under WAC 388-14A-4300.

(9) You must also make the following requests in writing:

(a) A request for a determination of controlling order under the Uniform Interstate Family Support Act (UIFSA), chapter 26.21A RCW, as described in WAC 388-14A-7305; and

(b) An objection to the determination of controlling order contained in a notice of support debt and registration issued by DCS under WAC 388-14A-7325. WAC 388-14A-7335 describes how to make this objection.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-6100, filed 3/29/07,

effective 4/29/07. Statutory Authority: RCW 74.08.090, 34.05.220. 01-03-089, § 388-14A-6100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-500.]

WAC 388-14A-6300 Duty of the administrative law judge in a hearing to determine the amount of a support obligation. (1) A support order entered under this chapter must conform to the requirements set forth in RCW 26.23.-050 (3) and (5). The administrative law judge (ALJ) must comply with the DSHS rules on child support and include a Washington state child support schedule worksheet when entering a support order.

(2) In hearings held under this chapter to contest a notice and finding of financial responsibility or a notice and finding of parental responsibility or other notice or petition, the ALJ must determine:

(a) The noncustodial parent's obligation to provide support under RCW 74.20A.057;

(b) The names and dates of birth of the children covered by the support order;

(c) The net monthly income of the noncustodial parent (NCP) and any custodial parent (CP);

(d) The NCP's share of the basic support obligation and any adjustments to that share, according to his or her circumstances;

(e) If requested by a party, the NCP's share of any special child-rearing expenses in a sum certain amount per month;

(f) The NCP's obligation to provide medical support under RCW 26.18.170;

(g) The NCP's accrued debt and order payments toward the debt in a monthly amount to be determined by the division of child support (DCS);

(h) The NCP's current and future monthly support obligation as a per month per child amount and order payments in that amount; and

(i) The NCP's total current and future support obligation as a sum certain and order payments in that amount.

(3) Having made the determinations required in subsection (2) above, the ALJ must order the NCP to make payments to the Washington state support registry (WSSR).

(4) The ALJ must allow DCS to orally amend the notice at the hearing to conform to the evidence. The ALJ may grant a continuance, when necessary, to allow the NCP or the CP additional time to present rebutting evidence or argument as to the amendment.

(5) The ALJ may not require DCS to produce or obtain information, documents, or witnesses to assist the NCP or CP in proof of defenses to liability. However, this rule does not apply to relevant, nonconfidential information or documents that DCS has in its possession.

[Statutory Authority: RCW 74.08.090, 34.05.220 (1)(a), 74.20A.055. 07-06-053, § 388-14A-6300, filed 3/2/07, effective 4/2/07. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.160. 06-09-015, § 388-14A-6300, filed 4/10/06, effective 5/11/06. Statutory Authority: RCW 26.23.050, 34.05.220, 74.08.090, 74.20A.310. 05-14-102, § 388-14A-6300, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 74.08.090, 26.23.050, 34.05.220, 74.20A.055, 74.20A.056, 45 CFR 303.11, 45 CFR 303.100. 01-03-089, § 388-14A-6300, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-100 and 388-11-210.]

WAC 388-14A-7100 The division of child support may register an order from another state for enforcement or modification. (1) A support enforcement agency, or a

party to a child support order or an income-withholding order for support issued by a tribunal of another state, may register the order in this state for enforcement pursuant to chapter 26.21A RCW.

(a) At the option of the division of child support (DCS), the support order or income-withholding order may be registered with the superior court pursuant to RCW 26.21A.505 or it may be registered with the administrative tribunal according to subsection (2) of this section. Either method of registration is valid.

(b) A support order or income-withholding order issued in another state is registered when the order is filed with the registering tribunal of this state.

(c) DCS may enforce a registered order issued in another state in the same manner and subject to the same procedures as an order issued by a tribunal of this state.

(d) DCS may assess and collect interest on amounts owed under support orders entered or established in a jurisdiction other than the state of Washington as provided in WAC 388-14A-7110.

(e) DCS may notify the parties that it is enforcing a non-Washington support order using the notice of support debt and demand for payment under WAC 388-14A-3304 or using the notice of support debt and registration as provided in this section and in WAC 388-14A-7110. Either method of notice is valid.

(2) DCS must give notice to the nonregistering party when it administratively registers a support order or income-withholding order issued in another state. DCS gives this notice with the Notice of Support Debt and Registration (NOSDR).

(a) The notice must inform the nonregistering party:

(i) That a registered order is enforceable as of the date of registration in the same manner as an order issued by a tribunal of this state;

(ii) That if a party wants a hearing to contest the validity or enforcement of the registered order, the party must request a hearing within twenty days after service of the notice on the nonregistering party within Washington state. If the nonregistering party was served with the notice outside of Washington state, the party has sixty days after service of the notice to request a hearing to contest the validity or enforcement of the registered order;

(iii) That failure to contest the validity or enforcement of the registered order in a timely manner will result in confirmation of the order and enforcement of the order and the alleged arrearages and precludes further contest of that order with respect to any matter that could have been asserted;

(iv) Of the amount of any alleged arrearages, including interest, if interest is being assessed under WAC 388-14A-7110; and

(v) Whether DCS has made a determination of controlling order under chapter 26.21A RCW, as described in WAC 388-14A-7325.

(b) The notice must be:

(i) Served on the nonregistering party by certified or registered mail or by any means of personal service authorized by the laws of the state of Washington; and

(ii) Served on the registering party by first class mail at the last known address; and

(iii) Accompanied by a copy of the registered order and any documents and relevant information accompanying the order submitted by the registering party.

(c) The effective date of a request for hearing to contest the validity or enforcement of the registered order is the date DCS receives the request.

(3) A party or support enforcement agency seeking to modify, or to modify and enforce, a child support order issued in another state may register the order in this state according to RCW 26.21A.540 through 26.21A.550.

(a) The order must be registered as provided in subsection (1)(a) if the order has not yet been registered.

(b) A petition for modification may be filed at the same time as a request for registration, or later. The petition must specify the grounds for modification.

(c) DCS may enforce a child support order of another state registered for purposes of modification, as if a tribunal of this state had issued the order, but the registered order may be modified only if the requirements of RCW 26.21A.550 are met.

(4) Interpretation of the registered order is governed by RCW 26.21A.515.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7100, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 26.21.016, 05-07-059, § 388-14A-7100, filed 3/11/05, effective 4/11/05. Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220, 74.20A.310, 01-03-089, § 388-14A-7100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-260 and 388-14-495.]

WAC 388-14A-7110 The division of child support may assess and collect interest on amounts owed under support orders entered or established in a jurisdiction other than Washington state. (1) The division of child support (DCS) may accept an interstate request to assess and collect interest when:

(a) The request is from:

- (i) Another state's IV-D agency;
- (ii) An Indian tribe;

(iii) A foreign country which has entered into a reciprocal agreement with the United States of America or with the state of Washington; or

(iv) A custodial parent (CP) or noncustodial parent (NCP) who resides outside of Washington state who has filed a petition under the Uniform Interstate Family Support Act (UIFSA), chapter 26.21A RCW.

(b) The party requesting that DCS assess and collect interest provides a calculation of the interest claimed which has been certified by a IV-D agency or a certified public accountant (CPA); and

(c) The support order was entered or established in a jurisdiction other than Washington state.

(2) When a foreign support order has been submitted for enforcement under UIFSA, DCS may, at its option, either:

(a) Use the notice of support debt and demand for payment to assess and collect interest on an out-of-state support order. See WAC 388-14A-3304 for the rules regarding the notice of support debt and demand for payment; or

(b) Use a notice of support debt and registration to assess and collect interest on the foreign order. See WAC 388-14A-7100 for the rules regarding registration of a foreign order.

(3) When an out of state order has been submitted for registration for enforcement and modification under UIFSA, DCS uses a notice of support debt and registration to assess and collect interest on the out of state order. See WAC 388-14A-7100 for the rules regarding registration of a foreign support order.

(4) Any hearing held on a notice of support debt and registration which includes a claim for interest is conducted in accordance with WAC 388-14A-7125 and 388-14A-7115.

(a) WAC 388-14A-7135 describes the procedures for confirmation of the registered order.

(b) WAC 388-14A-7135 describes the effect of confirmation of the registered order.

(5) At any time after the notice of support debt and registration becomes a final administrative order, DCS may update the amount of interest as provided in WAC 388-14A-7120.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7110, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 26.21.016, 05-07-059, § 388-14A-7110, filed 3/11/05, effective 4/11/05.]

WAC 388-14A-7125 What happens at a hearing on a notice of support debt and registration? A hearing under this section is for the limited purpose of determining if the nonregistering party can prove one or more of the defenses listed in RCW 26.21A.530(1).

(1) If the contesting party presents evidence establishing a full or partial defense under RCW 26.21A.530(1), the presiding officer may:

(a) Stay enforcement of the registered order;

(b) Continue the proceeding to allow the parties to gather additional relevant evidence; or

(c) Issue other appropriate orders.

(2) DCS may enforce an uncontested portion of the registered order by all remedies available under the law of this state.

(3) If the contesting party does not establish a defense under RCW 26.21A.530(1) to the validity or enforcement of the order, the presiding officer must issue an order confirming the registered order.

(4) The custodial parent (CP) or payee of the order may participate as a party to any hearing under this section.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7125, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7135 What is the effect of confirmation of a registered order on the finality of the support debt calculation? (1) Except as provided below in subsections (2) and (3) of this section, confirmation of a registered order precludes further contest of the order with respect to any matter that could have been asserted at the time of registration. Confirmation may occur:

(a) By operation of law upon failure to contest registration; or

(b) By order of the administrative law judge (ALJ).

(2) Confirmation of a registered order that does not include interest does not relieve the noncustodial parent (NCP) of any interest that may have accrued or may accrue under the confirmed order.

(a) If interest is later assessed, the NCP or the custodial parent (CP) may not dispute the confirmed amount of the support debt.

(b) The NCP or CP may dispute the amount of interest due and owing on that confirmed amount by requesting a conference board under WAC 388-14A-6400.

(3) Confirmation of a registered order that does include interest confirms only the amount of debt, including interest, that is due and owing for the indicated time periods. Such confirmation does not relieve the NCP of any interest that may have accrued or may accrue for any other time period.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7135, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7200 DCS can serve notices in other states under the Uniform Interstate Family Support Act.

(1) Except as specified in WAC 388-14A-3105, where grounds for personal jurisdiction exist under RCW 26.21A-100 or other Washington law, the division of child support (DCS) may serve the following legal actions in another state by certified mail, return receipt requested or by personal service, under chapter 26.21A RCW:

(a) A notice and finding of financial responsibility under WAC 388-14A-3115; and

(b) A notice and finding of parental responsibility under WAC 388-14A-3120;

(c) A notice of paternity test costs under WAC 388-14A-8300; or

(d) An affidavit of birth costs under WAC 388-14A-3555.

(2) A notice and finding of financial responsibility, a notice of paternity test costs, or an affidavit of birth costs becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the noncustodial parent (NCP), within sixty days of service in another state:

(a) Contacts DCS and signs an agreed settlement or consent order; or

(b) Files a written request for a hearing under:

(i) WAC 388-14A-3115 for a notice and finding of financial responsibility;

(ii) WAC 388-14A-3555 for an affidavit of birth costs; or

(iii) WAC 388-14A-8300 for a notice of paternity test costs.

(3) The effective date of a hearing request is the date DCS receives the hearing request.

(4) A notice and finding of parental responsibility becomes final and subject to immediate wage withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the NCP, within sixty days of service in another state:

(a) Contacts DCS and signs an agreed settlement or consent order;

(b) Files a written request for a hearing under WAC 388-14A-3120 with DCS; or

(c) Files a written request for paternity testing under WAC 388-14A-8300 to determine if he is the natural father of the dependent child named in the notice and cooperates in

the testing. A request for a hearing or paternity testing is filed on the date the request is received by DCS.

(5) If the results of paternity tests requested under subsection (4) of this section do not exclude the NCP as the natural father of the dependent child, the notice and finding of parental responsibility becomes final and subject to immediate wage withholding without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the NCP, within sixty days of service of the paternity test costs in another state:

(a) Contacts DCS and signs an agreed settlement or consent order; or

(b) Files a written request for a hearing under WAC 388-14A-3120.

(6) Administrative law judges and parties must conduct administrative hearings on notices served in another state under this section under the special rules of evidence and procedure in chapter 26.21A RCW and according to chapter 34.05 RCW.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7200, filed 3/29/07, effective 4/29/07. Statutory Authority: RCW 74.08.090, 34.05.220, 74.20A.055, 74.20A.056, 01-03-089, § 388-14A-7200, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-305 and 388-14-260.]

WAC 388-14A-7305 How do I ask DCS to do a determination of controlling order?

(1) When there are multiple current support orders covering the same obligor and the same children, a party to a support order may request that the division of child support (DCS) make a determination of controlling order under the Uniform Interstate Family Support Act, chapter 26.21A RCW.

(2) A request for a determination of controlling order may be made at any time, unless there has already been a determination of controlling order for the same obligor and children.

(3) DCS can provide a form which contains all the required elements for a request for determination of controlling order. A request for a determination of controlling order:

(a) Must be in writing;

(b) Must contain copies of any child support orders known to the requesting party. DCS waives this requirement if DCS has a true copy of the order on file; and

(c) State the reason the requesting party thinks DCS is enforcing the wrong order.

(4) A request for determination of controlling order does not constitute a petition for modification of a support order.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310, 07-08-055, § 388-14A-7305, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7315 When might DCS deny a request for a determination of controlling order?

(1) The division of child support (DCS) may deny a request for determination of controlling order made by a party to a child support order or another state's IV-D agency for the following reasons:

(a) There is only one support order for the obligor and the children;

(b) There is no current support owing under any existing support order for the obligor and the children; or

(c) There has already been a determination of controlling order performed for the obligor and the children.

(2) The denial of a request for determination of controlling order does not:

(a) Stop the party or other state's IV-D agency from bringing an action in superior court.

(b) Give rise to a right to administrative hearing.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7315, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7325 How does DCS notify the parties of its determination of the controlling order? (1)

When the division of child support (DCS) decides that a determination of controlling order is required, DCS reviews the multiple child support orders for the same obligor and children to determine which order should be enforced.

(a) If DCS decides that the order that should be enforced is a Washington order, we immediately refer the matter to the superior court for a determination of controlling order proceeding under chapter 26.21A RCW.

(b) If we decide that the order that should be enforced is an order which was not entered in the state of Washington, DCS follows the procedures set out in subsections (2) through (4) of this section.

(2) DCS serves a notice of support debt and registration (NOSDR) as provided in WAC 388-14A-7100. DCS serves the NOSDR on the obligor, the obligee, and on all identified interested parties. The NOSDR includes a determination of controlling order.

(3) DCS serves the notice on the nonrequesting party by certified mail, return receipt requested, or by personal service.

(4) DCS serves the notice on the requesting party and other interested parties by first class mail to the last known address.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7325, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7335 What happens if someone objects to DCS' proposed determination of controlling order? (1)

If any party objects to the proposed determination of controlling order issued under WAC 388-14A-7325, that objection must be in writing and signed under penalty of perjury. The division of child support (DCS) provides an objection form with the notice. The objection must contain:

(a) The reason the party objects to the determination of controlling order. Examples of reasons to object include, but are not limited to:

(i) There is another order that was not considered in making the determination;

(ii) The alleged controlling order has been vacated, suspended or modified by a later order, which is attached to the objection;

(iii) The issuing tribunal lacked personal jurisdiction over the nonpetitioning party;

(iv) The order was obtained by fraud; or

(v) Any other legal defense available under chapter 26.21A RCW.

(b) A copy of the order which the party believes should be the controlling order, if that order was not included with the notice.

(c) A statement of facts in support of the party's objection.

(2) DCS refers the objection to the prosecuting attorney or attorney general to bring an action for determination of controlling order under RCW 26.21A.130 in the superior court.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7335, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7345 What is the effect of a determination of controlling order on the finality of the debt calculation? As provided in RCW 26.21A.130, the final order in a proceeding for determination of controlling order operates as a final determination of the total amount of consolidated arrears and accrued interest, if any, under all of the support orders.

As provided in RCW 26.21A.130, the final order in a proceeding for determination of controlling order operates as a final determination of the total amount of consolidated arrears and accrued interest, if any, under all of the support orders.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7345, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7400 What can I do if I want to contest an interstate order to withhold income served on my employer? (1)

RCW 26.21A.425 provides that a noncustodial parent (NCP) may contest the validity or enforcement of an income-withholding order issued in another state and received directly by an employer in this state.

(2) Acting as an administrative tribunal under chapter 26.21A RCW, the division of child support (DCS) does not have the authority to quash income-withholding orders.

(3) An NCP who seeks to contest an income-withholding order as described in subsection (1) must seek relief in the superior court under RCW 26.18.140.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7400, filed 3/29/07, effective 4/29/07.]

WAC 388-14A-7500 What can I do if I am concerned about the release of my personal information in an interstate referral? (1)

When the division of child support (DCS) refers a case to another state, DCS must provide personal information regarding the parties to that other state. DCS notifies the party residing in Washington that we are preparing to refer your case and that we must release your personal information.

(2) If you believe that it would be dangerous for DCS to release your personal information to the other state, you may make a request for nondisclosure of your personal information under RCW 26.21A.255.

(3) The way DCS handles your request for nondisclosure depends on what version of the Uniform Interstate Family Support Act (UIFSA) has been adopted by the state where DCS is referring your case.

(a) The state may have enacted a version of UIFSA which is similar to the version enacted by the state of Washington as chapter 26.21A RCW (known as "UIFSA 2001"); or

(b) The state may have enacted a version of UIFSA which is similar to the version which was formerly enacted by the state of Washington as chapter 26.21 RCW (known as "UIFSA 1996").

(4) If DCS is making a referral to another state which has enacted UIFSA 2001:

(a) DCS must disclose your personal information to the other state.

(b) DCS sends to the other state a declaration for nondisclosure of information which you have signed under penalty of perjury.

(c) The other state must seal your personal information and may not disclose that information to the other party or to the public unless a tribunal orders disclosure of the information in the interest of justice, after a hearing in which the tribunal considers your (or your child's) health, safety and liberty.

(5) If DCS is making a referral to another state which has enacted UIFSA 1996:

(a) DCS holds a conference board under WAC 388-14A-6400.

(b) If the conference board finds that your (or your child's) health, safety or liberty would be unreasonably put at risk by the disclosure of the information, the conference board issues a nondisclosure finding.

(c) DCS does not disclose your personal information to the other state, and instead provides the other state with the nondisclosure finding.

[Statutory Authority: RCW 34.05.220(2), 43.20A.550, 74.04.055, 74.08.-090, 74.20.040, 74.20A.310. 07-08-055, § 388-14A-7500, filed 3/29/07, effective 4/29/07.]

Chapter 388-15 WAC

CHILD PROTECTIVE SERVICES

WAC

| | |
|------------|---|
| 388-15-009 | What is child abuse or neglect? |
| 388-15-049 | When must the department notify the parent, guardian or legal custodian of allegations of child abuse or neglect made against them? |

WAC 388-15-009 What is child abuse or neglect?

Child abuse or neglect means the injury, sexual abuse, or sexual exploitation of a child by any person under circumstances which indicate that the child's health, welfare, or safety is harmed, or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

(1) Physical abuse means the nonaccidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as:

- (a) Throwing, kicking, burning, or cutting a child;
- (b) Striking a child with a closed fist;
- (c) Shaking a child under age three;
- (d) Interfering with a child's breathing;
- (e) Threatening a child with a deadly weapon;

(f) Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare or safety.

(2) Physical discipline of a child, including the reasonable use of corporal punishment, is not considered abuse when it is reasonable and moderate and is inflicted by a parent or guardian for the purposes of restraining or correcting the child. The age, size, and condition of the child, and the location of any inflicted injury shall be considered in determining whether the bodily harm is reasonable or moderate. Other factors may include the developmental level of the child and the nature of the child's misconduct. A parent's belief that it is necessary to punish a child does not justify or permit the use of excessive, immoderate or unreasonable force against the child.

(3) Sexual abuse means committing or allowing to be committed any sexual offense against a child as defined in the criminal code. The intentional touching, either directly or through the clothing, of the sexual or other intimate parts of a child or allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in touching the sexual or other intimate parts of another for the purpose of gratifying the sexual desire of the person touching the child, the child, or a third party. A parent or guardian of a child, a person authorized by the parent or guardian to provide child-care for the child, or a person providing medically recognized services for the child, may touch a child in the sexual or other intimate parts for the purposes of providing hygiene, child care, and medical treatment or diagnosis.

(4) Sexual exploitation includes, but is not limited to, such actions as allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in:

- (a) Prostitution;
- (b) Sexually explicit, obscene or pornographic activity to be photographed, filmed, or electronically reproduced or transmitted; or

(c) Sexually explicit, obscene or pornographic activity as part of a live performance, or for the benefit or sexual gratification of another person.

(5) Negligent treatment or maltreatment means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, or safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, or safety. Negligent treatment or maltreatment includes, but is not limited, to:

(a) Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, or safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;

(b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or

(c) The cumulative effects of a pattern of conduct, behavior or inaction by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substan-

tial risk of injury to the physical, emotional, and/or cognitive development of a child.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.13.031, chapter 26.44 RCW, and 2005 c 512. 07-14-011, § 388-15-009, filed 6/22/07, effective 7/23/07. Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-009, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-049 When must the department notify the parent, guardian or legal custodian of allegations of child abuse or neglect made against them? The department must notify the parent, guardian or legal custodian of a child of the allegations of child abuse or neglect made against that person at the initial point of contact with that person, in a manner consistent with the laws maintaining the confidentiality of the persons making the allegations. Investigations of child abuse and neglect should be conducted in a manner that will not jeopardize the safety or protection of the child or the integrity of the investigation process.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.13.031, chapter 26.44 RCW, and 2005 c 512. 07-14-011, § 388-15-049, filed 6/22/07, effective 7/23/07. Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-049, filed 7/16/02 and 8/14/02, effective 2/10/03.]

Chapter 388-25 WAC

CHILD WELFARE SERVICES—FOSTER CARE

WAC

| | |
|-------------|---|
| 388-25-1000 | What is the state supplementary payment (SSP) that is administered by the children's administration (CA)? |
| 388-25-1010 | What are the eligibility requirements for the CA/SSP program? |
| 388-25-1020 | When will my eligibility for CA/SSP be determined? |
| 388-25-1030 | How will I know if I am eligible to receive a CA/SSP payment? |
| 388-25-1050 | What are my appeal rights if CA determines that I am not eligible for CA/SSP? |

WAC 388-25-1000 What is the state supplementary payment (SSP) that is administered by the children's administration (CA)? The children's administration state supplementary payment (CA/SSP) is a state-paid cash assistance program for specific eligible foster children with the children's administration. The CA/SSP program may be discontinued at any time and for any reason, and is limited to the funds available to children's administration for such payments. Receipt of a CA/SSP payment in any month does not guarantee payment for subsequent months even if all eligibility criteria remain met.

[Statutory Authority: RCW 74.04.050, 74.04.600, 74.04.620, 74.13.031, and 2002 c 371. 07-23-004, § 388-25-1000, filed 11/8/07, effective 12/9/07. Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1000, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1010 What are the eligibility requirements for the CA/SSP program? To be eligible to receive CA/SSP, you must meet all of the following eligibility requirements:

- (1) Be a child who has entered foster care (Title 45 CFR 1355.20);
- (2) Already receive Supplemental Security Income (SSI) benefits or have recently received notice of an award for such benefits; and

(3) Receive behavior rehabilitation services (BRS) for out-of-home placement services for all or part of a month; and

(4) Not receive foster care maintenance payments under Title IV-E of the Social Security Act (42 U.S.C. 670).

[Statutory Authority: RCW 74.04.050, 74.04.600, 74.04.620, 74.13.031, and 2002 c 371. 07-23-004, § 388-25-1010, filed 11/8/07, effective 12/9/07. Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1010, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1020 When will my eligibility for CA/SSP be determined? The SSP eligibility verification and payment process is usually completed two months following the month of your potential eligibility for an SSP payment. You will receive an SSP payment when all of the eligibility criteria (WAC 388-25-1010) have been verified. Children who have recently received notice of an award for SSI will receive a CA/SSP payment beginning the month the Social Security Administration places them into pay status, if all other eligibility criteria are met for that month.

[Statutory Authority: RCW 74.04.050, 74.04.600, 74.04.620, 74.13.031, and 2002 c 371. 07-23-004, § 388-25-1020, filed 11/8/07, effective 12/9/07. Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1020, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1030 How will I know if I am eligible to receive a CA/SSP payment? Once you have been identified as eligible for a CA/SSP payment, CA will send out written notification to the current SSI representative payee.

[Statutory Authority: RCW 74.04.050, 74.04.600, 74.04.620, 74.13.031, and 2002 c 371. 07-23-004, § 388-25-1030, filed 11/8/07, effective 12/9/07. Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1030, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1050 What are my appeal rights if CA determines that I am not eligible for CA/SSP? In the event that your eligibility for CA/SSP payments is denied or terminated, or the amount of such payments is reduced, you have the right to file an informal complaint pursuant to RCW 74.13.045 and chapter 388-39A WAC and to request a hearing under chapter 34.05 RCW and chapter 388-02 WAC, except that there is no right to a hearing if the reason for the change is lack of funding.

[Statutory Authority: RCW 74.04.050, 74.04.600, 74.04.620, 74.13.031, and 2002 c 371. 07-23-004, § 388-25-1050, filed 11/8/07, effective 12/9/07. Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1050, filed 5/9/05, effective 6/9/05.]

Chapter 388-61A WAC

SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE

(Formerly chapter 284-554 WAC)

WAC

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|--------------|---|
| 388-61A-0025 | What definitions apply to domestic violence shelters and services? |
| 388-61A-0135 | What are the additional requirements for a shelter home? |
| 388-61A-0146 | What information must the domestic violence service keep confidential? |
| 388-61A-0147 | What information can be disclosed? |
| 388-61A-0148 | What information needs to be included in a written waiver of confidentiality? |

388-61A-0149 What information must be provided to clients about their right to confidentiality?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-61A-0185 What are my rights if DSHS suspends, revokes, or denies funding? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0185, filed 3/16/01, effective 4/16/01.] Repealed by 07-04-098, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162.

388-61A-0190 Will I be notified if my funding has been suspended, revoked, or denied? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0190, filed 3/16/01, effective 4/16/01.] Repealed by 07-04-098, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162.

388-61A-0195 How do I request an agency hearing? [Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0195, filed 3/16/01, effective 4/16/01.] Repealed by 07-04-098, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162.

WAC 388-61A-0025 What definitions apply to domestic violence shelters and services? "Advocacy-based counseling" means that the client is involved with an advocate counselor in individual, family, or group sessions with the primary focus on safety planning, empowerment, and education of the client through reinforcing the client's autonomy and self-determination.

"Advocate counselor" means a trained staff person who works in a domestic violence service and provides advocacy-based counseling, counseling, and supportive temporary shelter services to clients.

"Client" means a victim of domestic violence or dependent child of the victim.

"Cohabitant" means a person who is married or is living with a person as a husband or wife at the present time or at some time in the past. Any person who has one or more children in common with another person, regardless of whether they have been married or have lived together at any time, is considered a cohabitant.

"Confidential communication" means all information, oral, written or nonverbal, transmitted between a victim of domestic violence and a domestic violence advocate counselor in the course of their relationship and in confidence by means which, so far as the victim is aware, does not disclose the information to a third person.

"Confidential information" includes, but is not limited to, any information, advice, notes, reports, statistical data, memoranda, working papers, records or the like, made or given during the relationship between a victim of domestic violence and a domestic violence advocate counselor, however maintained. Confidential information specifically includes the name, address, telephone number, Social Security number, date of birth, nine-digit ZIP code, and other personally identifying information, physical appearance of, and case file or history of, any victim of domestic violence who seeks or has received services from a domestic violence advocate counselor or domestic violence service.

"Department" means the department of social and health services (DSHS).

"Domestic violence" includes, but is not limited to, the criminal offenses defined in RCW 10.99.020 when committed by one cohabitant against another.

"Domestic violence service" means an agency that provides shelter, advocacy, and counseling for domestic violence clients in a safe, supportive environment.

"Lodging unit" means one or more rooms used for a victim of domestic violence including rooms used for sleeping or sitting.

"Personally identifying information" includes, but is not limited to, first and last name, home or other physical address, telephone number, Social Security number, date of birth, nine-digit ZIP code, and other personally identifying information, physical appearance of, and case file or history of, any victim of domestic violence who seeks or has received services from a domestic violence advocate counselor or domestic violence service, or such other information which, taken individually or together with other identifying information, could identify a particular individual.

"Program" means the DSHS domestic violence program.

"Safe home" means a shelter that has two or less lodging units and has a written working agreement with a domestic violence service.

"Secretary" means the DSHS secretary or the secretary's designee.

"Shelter" means a safe home or shelter home that provides temporary refuge and adequate food and clothing offered on a twenty-four hour, seven-day-per-week basis to victims of domestic violence and their children.

"Shelter home" means a shelter that has three or more lodging units and either is a component of or has a written working agreement with a domestic violence service.

"Staff" means persons who are paid or who volunteer services and are a part of a domestic violence service.

"Victim" means a cohabitant who has been subjected to domestic violence.

"We, us and our" refers to the department of social and health services and its employees.

"You, I and your" refers to the domestic violence service or shelter.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0025, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0025, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0135 What are the additional requirements for a shelter home? Shelter homes must meet the following additional requirements in order for a domestic violence service to contract with us:

(1) When a shelter home is not a component of a domestic violence service, the shelter home and domestic violence service must have a written working agreement before the shelter home receives clients from the domestic violence service. The written working agreement must include:

(a) Confirmation that the domestic violence service has inspected the shelter home and that the shelter home complies with the general facility and additional requirements for shelter homes;

(b) How the domestic violence service will provide supportive services to shelter home residents; and

(c) Verification that shelter home staff received initial basic training as outlined in this rule by the domestic violence service.

(2) Shelter homes must provide at least one toilet, sink, and bathing facility for each fifteen clients or fraction of this number. The floors of all toilet and bathing facilities must be resistant to moisture.

(3) You must have at least one telephone at the shelter for incoming and outgoing calls. Next to the telephone in shelter homes you must post:

(a) Emergency telephone numbers; and

(b) Instructions on how residents can access domestic violence service staff.

(4) In shelter homes all bathrooms, toilet rooms, laundry rooms, and janitor closets containing wet mops and brushes must have natural or mechanical ventilation in order to prevent objectionable odors and condensation.

(5) When staff serve food to clients in shelter homes, the staff must prepare the food in compliance with WAC 246-215-190, Temporary food service establishment.

(6) Shelter homes must develop and post hygiene procedures for handling and storing diapers and sanitizing the changing area.

(7) Shelter homes must request an annual fire and life safety inspection from their local fire department or fire marshal. The domestic violence service must maintain documentation of the request as well as any report issued as a result of the inspection. Any violations noted by the inspector must be immediately corrected by the domestic violence service.

(8) Shelter homes must meet the following requirements for bedrooms:

(a) Bedrooms must have a minimum ceiling height of seven and [one] half feet;

(b) Bedrooms must provide at least fifty square feet of usable floor area per bed; and

(c) Floor area where the ceiling height is less than five feet cannot be considered as usable floor area.

(9) When clients are residing in a shelter home at least one domestic violence service staff member must be present or on-call to go to the shelter home twenty-four-hours a day, seven-days-per-week.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0135, filed 2/6/07, effective 3/9/07. Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0135, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0146 What information must the domestic violence service keep confidential? (1) Agents, employees, and volunteers of a domestic violence service must maintain the confidentiality of all personally identifying information, confidential communications, and all confidential information as defined by WAC 388-61A-0025. Information which individually or together with other information could identify a particular victim of domestic violence must also be kept confidential.

(2) Any reports, records, working papers, or other documentation, including electronic files, maintained by the domestic violence service, including information provided to the domestic violence service on behalf of the client. Any information considered privileged by statute, rule, regulation or policy that is shared with the domestic violence service on

behalf of the client shall not be divulged without a valid written waiver of the privilege that is based on informed consent, or as otherwise required by law.

(3) You must comply with the provisions of this section regarding confidential communications concerning clients regardless of when the client received the services of the domestic violence service.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0146, filed 2/6/07, effective 3/9/07.]

WAC 388-61A-0147 What information can be disclosed? (1) You can disclose confidential information only when:

(a) The client provides informed, written consent to the waiver of confidentiality that relates only to the client or the client's dependents;

(b) Failure to disclose is likely to result in a clear, imminent risk of serious physical injury or death of the client or other person;

(c) Disclosure is required under chapter 26.44 RCW, Abuse of children;

(d) Release of information is made to an authorized person to the extent necessary for a management audit, financial audit, or program evaluation with the following restrictions:

(i) The authorized person shall sign a confidentiality agreement with the domestic violence service that demonstrates his or her acknowledgment of the requirement that client information be kept confidential;

(ii) No personally identifying information about the client can be copied or removed from the domestic violence service;

(iii) No copies of working papers or other documentation about the client can be removed from the domestic violence service; and

(iv) The client file cannot be removed from the premises of the domestic violence service.

(e) Release of information is otherwise required by law or court order, or following in-camera review pursuant to RCW 70.123.075, with the following additional requirements:

(i) The domestic violence service shall make reasonable attempts to provide notice to the person affected by the disclosure of the information; and

(ii) If personally identifying information is or will be disclosed, the domestic violence service shall take steps necessary to protect the privacy and safety of the persons affected by the disclosure of information.

(2) Any release of information subject to any of the exceptions set forth above shall be limited to the minimum necessary to meet the requirement of the exception, and such release does not void the client's right to confidentiality and privilege on any other confidential communication between the client and the domestic violence service.

(3) In the case of an unemancipated minor, the minor and the parent or guardian must provide the written consent. Consent for release may not be given by a parent who has abused the minor or the minor's other parent. In the case of a disabled adult who has been appointed a guardian, the guardian must consent to release unless the guardian is the abuser of the disabled adult.

(4) To comply with federal, state, tribal, or territorial reporting, evaluation, or data collection requirements, domestic violence programs may disclose nonpersonally identifying data in the aggregate regarding services to their clients and nonpersonally identifying demographic information.

(5) If requested, a copy of the disclosed information shall be provided to the client.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0147, filed 2/6/07, effective 3/9/07.]

WAC 388-61A-0148 What information needs to be included in a written waiver of confidentiality? (1) To be valid, a written waiver of confidentiality must:

- (a) Be voluntary;
- (b) Relate only to the client or the client's dependents;
- (c) Clearly describe the scope and any limitations of the information to be released;
- (d) Include an expiration date for the release; and
- (e) Inform the client that consent can be withdrawn at any time whether it is made orally or in writing.

(2) If the written waiver of confidentiality does not include an expiration date, it shall expire ninety days after the date it was signed.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0148, filed 2/6/07, effective 3/9/07.]

WAC 388-61A-0149 What information must be provided to clients about their right to confidentiality? (1) You must provide each client with a written "notice of rights" at the time of initial and any subsequent intake into the domestic violence service. At a minimum, the notice of rights shall inform clients of the following:

- (a) The client's right to privacy and confidentiality of the information shared with the domestic violence service;
- (b) Exceptions to confidentiality as described in this chapter;
- (c) That if the client signs a written waiver of confidentiality that allows their information to be shared with others, the client does not give up their right to have that information protected under other statutes, rules or laws;
- (d) That the client has the right to withdraw a written waiver of confidentiality at any time; and
- (e) That the domestic violence service will not condition the provision of services to the client based on a requirement that the client sign one or more releases of confidential information.

(2) Information on the "notice of rights" must be explained to the client at the time of intake into the domestic violence service and then again, at the time the client is considering whether to sign a written waiver of confidentiality.

[Statutory Authority: Chapter 70.123 RCW, 2006 c 259, and federal PL 109-162. 07-04-098, § 388-61A-0149, filed 2/6/07, effective 3/9/07.]

Chapter 388-71 WAC

HOME AND COMMUNITY SERVICES AND PROGRAMS

WAC

388-71-0540 When will the department, AAA, or managed care entity deny payment for services of an individual provider or home care agency provider?

WAC 388-71-0540 When will the department, AAA, or managed care entity deny payment for services of an individual provider or home care agency provider? The department, AAA, or managed care entity will deny payment for the services of an individual provider or home care agency provider who:

- (1) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;
- (2) Is the natural/step/adoptive parent of a minor client aged seventeen or younger receiving services under Medicaid personal care;
- (3) Is a foster parent providing personal care to a child residing in their licensed foster home;
- (4) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;
- (5) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;
- (6) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;
- (7) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05865;
- (8) Is already meeting the client's needs on an informal basis, and the client's assessment or reassessment does not identify any unmet need; and/or
- (9) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

In addition, the department, AAA, or managed care entity may deny payment to or terminate the contract of an individual provider as provided under WAC 388-71-0546, 388-71-0551, and 388-71-0556.

[Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-71-0540, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-71-0540, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0540, filed 5/17/05, effective 6/17/05. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-0540, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095. 01-11-019, § 388-71-0540, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830. 00-03-043, § 388-71-0540, filed 1/13/00, effective 2/13/00.]

Chapter 388-76 WAC

ADULT FAMILY HOME MINIMUM LICENSING REQUIREMENTS

WAC

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| 388-76-10000 | Definitions. | 388-76-10325 | Resident record—Legal documents—If available. |
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| 388-76-10165 | Criminal history background check—Valid for two years. | 388-76-10490 | Medication disposal—Written policy—Required. |
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| 388-76-10300 | Tuberculosis—Declining a test. | 388-76-10625 | Resident rights—Quality of life—Meetings. |
| 388-76-10305 | Tuberculosis—Reporting positive skin reactions—Required. | 388-76-10630 | Resident rights—Quality of life—Adult family home response to issues. |
| 388-76-10310 | Tuberculosis—Skin test records. | 388-76-10635 | Resident rights—Quality of life—Work. |
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| 388-76-10320 | Resident record—Content. | 388-76-10645 | Resident rights—Quality of life—Reasonable accommodation. |
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| | | 388-76-10655 | Physical restraints. |
| | | 388-76-10660 | Chemical restraints. |
| | | 388-76-10665 | Involuntary seclusion. |
| | | 388-76-10670 | Prevention of abuse. |
| | | 388-76-10675 | Adult family home rules and policies related to abuse—Required. |

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| 388-76-10680 | Staff behavior related to abuse. | | |
| 388-76-10685 | Bedrooms. | | |
| 388-76-10690 | Bedroom usable floor space—In adult family homes after the effective date of this chapter. | 388-76-535 | Authority. [Statutory Authority: RCW 70.128.040, 69.41.085, 02-15-081, § 388-76-535, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-535, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10695 | Building codes—Structural requirements. | | |
| 388-76-10700 | Building official—Inspection and approval. | | |
| 388-76-10705 | Common use areas. | | |
| 388-76-10710 | Construction and remodeling—Relocation of residents. | | |
| 388-76-10715 | Doors—Ability to open. | | |
| 388-76-10720 | Electronic monitoring equipment—Audio monitoring and video monitoring. | | |
| 388-76-10725 | Electronic monitoring equipment—Resident requested use. | 388-76-540 | Definitions. [Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-540, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.08.090, 74.09-520, and 74.39A.090. 02-21-098, § 388-76-540, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-540, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-540, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10730 | Grab bars and hand rails. | | |
| 388-76-10735 | Kitchen facilities. | | |
| 388-76-10740 | Lighting. | | |
| 388-76-10745 | Local codes and ordinances. | | |
| 388-76-10750 | Safety and maintenance. | | |
| 388-76-10755 | Sewage and liquid wastes. | | |
| 388-76-10760 | Site. | | |
| 388-76-10765 | Storage. | | |
| 388-76-10770 | Telephones. | | |
| 388-76-10775 | Temperature and ventilation. | | |
| 388-76-10780 | Toilets and bathing facilities. | | |
| 388-76-10785 | Water hazards—Enclosures and safety devices. | | |
| 388-76-10790 | Water supply. | | |
| 388-76-10795 | Windows. | 388-76-545 | License required. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-545, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10800 | Adult family home located outside of public fire protection. | | |
| 388-76-10805 | Automatic smoke detectors. | | |
| 388-76-10810 | Fire extinguishers. | | |
| 388-76-10815 | Notice required—Compliance with building code and fire protection. | | |
| 388-76-10820 | Resident evacuation capabilities and location of resident bedrooms. | 388-76-550 | License application. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-550, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-550, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10825 | Space heaters and stoves. | | |
| 388-76-10830 | Emergency and disaster plan—Required. | | |
| 388-76-10835 | Elements of an emergency and disaster plan. | | |
| 388-76-10840 | Emergency food supply. | | |
| 388-76-10845 | Emergency drinking water supply. | | |
| 388-76-10850 | Emergency medical supplies. | | |
| 388-76-10855 | Emergency and disaster plan training—Required. | | |
| 388-76-10860 | Fire drill plan and procedures for emergency evacuation—Required. | 388-76-555 | License fees. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-555, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10865 | Emergency evacuation from adult family home. | | |
| 388-76-10870 | Resident evacuation capability levels—Identification required. | | |
| 388-76-10880 | Emergency evacuation adult family home floor plan. | | |
| 388-76-10885 | Elements of emergency evacuation floor plan. | | |
| 388-76-10890 | Posting the emergency evacuation floor plan—Required. | 388-76-560 | License eligibility. [Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-560, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-560, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-560, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10895 | Emergency evacuation drills—Frequency and participation. | | |
| 388-76-10900 | Documentation of emergency evacuation drills—Required. | | |
| 388-76-10905 | Emergency evacuation—Notification of department required. | | |
| 388-76-10910 | Inspections—Complaint investigations—Monitoring visits—General. | | |
| 388-76-10915 | Department staff access—Willful interference prohibited. | | |
| 388-76-10920 | Inspection and investigation reports—Provided by department. | 388-76-565 | Resident manager and live-in requirements. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-565, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10925 | Disclosure of inspection and complaint investigation reports. | | |
| 388-76-10930 | Plan of correction (POC)—Required. | | |
| 388-76-10935 | Washington protection and advocacy—Long-term care ombudsman—Official duties—Penalty for interference. | 388-76-570 | Additional license requirements—Multiple facility providers. [Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-76-570, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-570, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-570, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-10940 | Remedies—Generally. | | |
| 388-76-10945 | Remedies—Serious risk—Recurring violations—Uncorrected violations. | | |
| 388-76-10950 | Remedies—History and actions by individuals. | | |
| 388-76-10955 | Remedies—Department must impose remedies. | | |
| 388-76-10960 | Remedies—Department may impose remedies. | | |
| 388-76-10965 | Remedies—Specific—Denial of application for license. | | |
| 388-76-10970 | Remedies—Specific—Condition(s) on license. | | |
| 388-76-10975 | Remedies—Specific—Civil penalties. | | |
| 388-76-10980 | Remedies—Specific—Stop placement—Admissions prohibited. | | |
| 388-76-10985 | Remedies—May extend to multiple homes. | | |
| 388-76-10990 | Informal dispute resolution (IDR). | 388-76-575 | Licensing of state employees. [Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-575, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW |
| 388-76-10995 | Notice, hearing rights, and effective dates relating to imposition of remedies. | | |

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| | 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-575, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-580 | License capacity. [Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-580, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-585 | Change of provider or provider address. [Statutory Authority: RCW 70.128.040. 05-17-158, § 388-76-585, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-585, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-590 | Specialty adult family homes. [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-590, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-590, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59000 | What authority does the department have to adopt rules related to specialty homes? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59000, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59010 | What types of specialty adult family home designations are there? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59010, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59050 | What is required in order to obtain the specialty designation? [Statutory Authority: RCW 70.128.040, 70.128.-060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59050, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59060 | Are adult family home providers required to obtain more than one specialty designation if an individual resident has more than one specialty need? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59060, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59070 | Are adult family home providers required to obtain more than one specialty designation if they serve two or more residents with different specialty needs? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59070, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59080 | When will providers be required to become specialty adult family homes in order to serve persons with mental illness or dementia? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59080, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-59090 | When will providers be required to become specialty adult family homes in order to serve persons with developmental disabilities? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59090, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-595 | | | Inspections and ombudsman visits. [Statutory Authority: RCW 70.128.040. 05-17-158, § 388-76-595, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-595, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-595, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-600 | | | General resident rights. [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-600, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.-060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-600, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60000 | | | What are resident rights? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60000, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60010 | | | Why do providers need to know resident rights? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60010, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60020 | | | Is the provider required to supply information to potential residents and current residents, or the resident's representative? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60020, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60030 | | | When must this information be supplied? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60030, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60040 | | | Must the information be updated and supplied again in advance of changes? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60040, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60050 | | | What information is the provider required to supply to potential residents and current residents? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60050, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60060 | | | Do residents have rights that are not listed here? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60060, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-60070 | | | What are some of the other resident rights that must be considered? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60070, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-605 | | | Restraints. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76- |

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| | 605, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-605, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | and 18.88A.230. 96-14-003 (Order 3984), § 388-76-615, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-610 | Resident assessment. [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-610, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-610, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61500 | What is a negotiated care plan? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61500, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61000 | Is an assessment needed before a person can be admitted to an adult family home? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61000, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61510 | When must the negotiated care plan be developed? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-15-081, § 388-76-61510, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61510, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61010 | Under what circumstances can a provider admit or continue services for a person? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61010, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61520 | How does the negotiated care plan fit in with the assessment and preliminary service plan? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61520, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61020 | What must be included in the resident assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61020, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61530 | Who must be involved in the development of the negotiated care plan? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61530, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61030 | How does the preliminary service plan fit within the resident assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61030, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61540 | Who must sign the negotiated care plan? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61540, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61040 | Is the use of an approved form required for the assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61040, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61550 | How often must the negotiated care plan be reviewed and revised? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61550, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61050 | Who can do the assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61050, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61560 | When does the department's case manager get a copy of the negotiated care plan? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61560, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61060 | In emergency situations, can a provider admit a resident without an assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61060, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-61570 | How are payment rate changes authorized for residents receiving services paid for fully or partially by the department? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61570, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61070 | Does the assessment have to be updated? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61070, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-620 | Provision of services and care. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-620, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-620, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-61080 | Who is qualified to update the assessment? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61080, filed 5/29/98, effective 7/1/98.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-625 | Nurse delegation—Training and registration. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-625, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-615 | Negotiated care plan. [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-615, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. | 388-76-630 | Performance of delegated nursing care tasks. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-630, filed 6/19/96, |

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| | effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| 388-76-635 | Nurse delegation—Penalties. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-635, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.-060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-635, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-650 |
| 388-76-64010 | What are the rules the provider must follow in all situations involving resident medications? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64010, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-655 |
| 388-76-64015 | What defines the type of help a resident may need when taking their medication? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64015, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| 388-76-64020 | What must the provider include in the negotiated care plan for residents who are independent with self-administration? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64020, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-660 |
| 388-76-64025 | How do a resident and provider initiate self-administration with assistance? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64025, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| 388-76-64030 | What must the provider monitor when implementing self-administration with assistance? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64030, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-665 |
| 388-76-64035 | What other situations must the provider monitor when self-administration with assistance occurs for a resident? [Statutory Authority: RCW 70.128.040, 69.41.-085. 02-20-005, § 388-76-64035, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-670 |
| 388-76-64040 | What must the provider do when there is a need to alter medications during self-administration with assistance? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64040, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| 388-76-64045 | What other types of assistance can a nonpractitioner provide? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64045, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-675 |
| 388-76-64050 | Who can fill medication organizers and what is required? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64050, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-680 |
| 388-76-64055 | What documentation is the provider required to include in the resident's daily medication log? [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64055, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| 388-76-645 | Resident activities. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 | 388-76-685 |
| | (Order 3984), § 388-76-645, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Food services. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-650, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | General management and administration. [Statutory Authority: RCW 70.128.040. 05-17-158, § 388-76-655, filed 8/22/05, effective 9/22/05; 03-14-018, § 388-76-655, filed 6/19/03, effective 7/20/03. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.-020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-76-655, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-655, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.-060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-655, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Training. [Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-76-660, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-660, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-660, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Resident records. [Statutory Authority: RCW 70.128.-040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-665, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-665, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Disaster and emergency preparedness. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-670, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-670, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Reporting requirements. [Statutory Authority: RCW 74.34.165, 74.34.020, and 74.34.035. 04-01-032, § 388-76-675, filed 12/8/03, effective 1/8/04. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-675, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-675, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Infection control and communicable disease. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-680, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-680, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | |
| | Criminal history disclosure and background inquiries. [Statutory Authority: RCW 70.128.040. 05-17-158, § 388-76-685, filed 8/22/05, effective 9/22/05. Statutory | |

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| | Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-685, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-685, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | | |
| 388-76-690 | Advance directives, guardianship, and decision making. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-690, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-690, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-735 | Kitchen facilities. [Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-735, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-695 | Protection of resident funds—Liquidation or transfer. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-695, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-695, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-740 | Telephones. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-740, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-700 | Resident relocation due to closure. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-700, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-745 | Storage. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-745, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-705 | Remedies. [Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-705, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-705, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-750 | Laundry. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-750, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-710 | Notice, hearing rights, and effective dates relating to imposition of remedies. [Statutory Authority: RCW 70.128.040, 69.41.085. 02-15-081, § 388-76-710, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-710, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-755 | Local ordinances. [Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-755, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-715 | Dispute resolution. [Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-715, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.-040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-715, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-760 | Site. [Statutory Authority: RCW 70.128.040, 70.128.-060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-760, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-720 | Common use areas. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-720, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-76505 | What physical structure requirements must the provider ensure that the home meets? [Statutory Authority: RCW 70.128.040 and chapter 70.128 RCW. 05-07-137, § 388-76-76505, filed 3/22/05, effective 4/22/05. Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76505, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-725 | Bedrooms. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-725, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-76510 | What are the resident emergency evacuation requirements that providers must address? [Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76510, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| 388-76-730 | Toilets and bathing facilities. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-730, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. | 388-76-76515 | What fire safety and emergency requirements must the provider have in the home? [Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76515, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| | | 388-76-76520 | What is required of the provider for emergency evacuation drills? [Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76520, filed 9/18/02, effective 10/19/02.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| | | 388-76-770 | Safety and maintenance. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-770, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. |
| | | 388-76-775 | Pets. [Statutory Authority: RCW 70.128.040, 70.128.-060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76- |

- 775, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW.
- 388-76-780 Lighting. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-780, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW.
- 388-76-785 Temperature and ventilation. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-785, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW.
- 388-76-790 Water supply. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-790, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW.
- 388-76-795 Sewage and liquid wastes. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-795, filed 6/19/96, effective 7/20/96.] Repealed by 07-21-080, filed 10/16/07, effective 1/1/08. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW.

WAC 388-76-10000 Definitions. "Abandonment"

means action or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult:

(1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain or mental anguish; and

(2) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **"Sexual abuse"** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not consensual.

(b) **"Physical abuse"** means a willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or chemical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and

verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Adult family home" means:

(1) A residential home in which a person or entity are licensed to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services; and

(2) For the purposes of this chapter, any person or entity who has been granted a license to operate an adult family home.

"Affiliated with an applicant" means any person listed on the application as a partner, officer, director, resident manager, or majority owner of the applying entity, or is the spouse of the applicant.

"Applicant" means an individual, partnership, corporation, or other entity seeking a license to operate an adult family home.

"Capacity" means the maximum number of persons in need of personal or special care permitted in an adult family home at a given time and includes related children or adults in the home who receive personal or special care and services.

"Caregiver" for purposes other than training, means any person eighteen years of age or older responsible for providing direct personal or special care to a resident and who is not the provider, entity representative, a student or volunteer.

"Dementia" is defined as a condition documented through the assessment process required by WAC 388-76-10335.

"Department" means the Washington state department of social and health services.

"Department case manager" means the department authorized staff person or designee assigned to negotiate, monitor, and facilitate a care and services plan for residents receiving services paid for by the department.

"Developmental disability" means:

(1) A person who meets the eligibility criteria defined by the division of developmental disabilities under WAC 388-823-0040; or

(2) A person with a severe, chronic disability which is attributable to cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (i.e., autism); and

(a) The condition was manifested before the person reached age eighteen;

(b) The condition is likely to continue indefinitely; and

(c) The condition results in substantial functional limitations in three or more of the following areas of major life activities:

(i) Self-care;

(ii) Understanding and use of language;

- (iii) Learning;
- (iv) Mobility;
- (v) Self-direction; and
- (vi) Capacity for independent living.

"Direct supervision" means oversight by a person who has demonstrated competency in the basic training and specialty training if required, or who has been exempted from the basic training requirements and is:

- (1) On the premises; and
- (2) Quickly and easily available to the caregiver.

"Entity provider" means any corporation, partnership, association, or limited liability company that is licensed under this chapter to operate an adult family home.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage.

"Entity representative" means the individual designated by an entity provider who is responsible for the daily operation of the adult family home.

"Home" means adult family home.

"Indirect supervision" means oversight by a person who:

- (1) Has demonstrated competency in the basic training and specialty training if required; or
- (2) Has been exempted from the basic training requirements; and
- (3) Is quickly and easily available to the care giver, but not necessarily on-site.

"Inspection" means an on-site visit by department personnel to determine the adult family home's compliance with this chapter and chapters 70.128, 70.129, 74.34 RCW, and other applicable rules and regulations.

"Mandated reporter" means an employee of the department, law enforcement, officer, social worker, professional school personnel, individual provider, an employee of a facility, an employee of a social service, welfare, mental health, adult day health, adult day care, or hospice agency, county coroner or medical examiner, Christian Science practitioner, or health care provider subject to chapter 18.130 RCW. For the purpose of the definition of a mandated reporter, **"Facility"** means a residence licensed or required to be licensed under chapter 18.20 RCW (boarding homes), chapter 18.51 RCW (nursing homes), chapter 70.128 RCW (adult family homes), chapter 72.36 RCW (soldiers' homes), chapter 71A.20 RCW (residential habilitation centers), or any other facility licensed by the department.

"Medical device" as used in this chapter, means any piece of medical equipment used to treat a resident's assessed need.

- (1) A medical device is not always a restraint and should not be used as a restraint;
- (2) Some medical devices have considerable safety risks associated with use; and
- (3) Examples of medical devices with known safety risks when used are transfer poles, Posey or lap belts, and side rails.

"Medication administration" means giving resident medications by a person legally authorized to do so, such as a physician, pharmacist or nurse.

"Medication organizer" is a container with separate compartments for storing oral medications organized in daily doses.

"Mental illness" is defined as an Axis I or II diagnosed mental illness as outlined in volume IV of the Diagnostic and Statistical Manual of Mental Disorders (a copy is available for review through the aging and disability services administration).

"Multiple facility provider" means an individual or entity provider who is licensed to operate more than one adult family home.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.41.100.

"Nurse delegation" means a registered nurse transfers the performance of selected nursing tasks to competent nursing assistants in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the resident.

"Over-the-counter medication" is any medication that can be purchased without a prescriptive order, including but not limited to vitamin, mineral, or herbal preparations.

"Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs and does not include assistance with tasks performed by a licensed health professional.

"Physical restraint" means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and is not required to treat the resident's medical symptoms.

"Practitioner" includes a physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant licensed in the state of Washington.

"Prescribed medication" refers to any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

"Provider" means any person or entity that is licensed under this chapter to operate an adult family home.

"Qualified staff" means a person who:

- (1) Is employed, directly or by contract, by an adult family home; and
- (2) Meets all of the requirements of a provider, entity representative, resident manager or caregiver.

"Resident" means any adult unrelated to the provider who lives in the adult family home and who is in need of care and for decision-making purposes, the term "resident" includes the resident's surrogate decision maker following state law or at the resident's request.

"Resident manager" means a person employed or designated by the provider or entity representative to manage the adult family home.

"Significant change" means:

- (1) A lasting change, decline or improvement in the resident's baseline physical, mental or psychosocial status;
- (2) The change is significant enough so the current assessment and/or negotiated care plan do not reflect the resident's current status; and
- (3) A new assessment may be needed when the resident's condition does not return to baseline within a two week period of time.

"Special care" means care beyond personal care services as defined in this section.

"Staff" means any person who:

- (1) Is employed, directly or by contract, by an adult family home; and
- (2) Provides care and services to any resident.

"Unsupervised" means not in the presence of:

- (1) Another employee or volunteer from the same business or organization; or
- (2) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization.

"Usable floor space" means resident bedroom floor space exclusive of:

- (1) Toilet rooms;
- (2) Closets;
- (3) Lockers;
- (4) Wardrobes;
- (5) Vestibules, and
- (6) The space required for the door to swing if the bedroom door opens into the resident bedroom.

"Willful" means the deliberate or nonaccidental action or inaction by an alleged perpetrator that he/she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish.

"Vulnerable adult" includes a person:

- (1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself;
- (2) Found incapacitated under chapter 11.88 RCW;
- (3) Who has a developmental disability as defined under RCW 71A.10.020;
- (4) Admitted to any facility;
- (5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or
- (6) Receiving services from a provider.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10000, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10005 License—Required. (1) Any person or entity must have a license by the department to operate an adult family home.

(2) No person or entity may provide personal care, special care, and room and board for more than one resident without a license.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10005, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10010 License—Valid and not transferable. (1) The adult family home is not required to renew the license each year.

(2) The license remains valid unless:

- (a) The department takes enforcement action to suspend or revoke the license per law;
 - (b) The home voluntarily surrenders the license and closes the home;
 - (c) The home relinquishes the license; or
 - (d) The home fails to pay the annual licensing fee.
- (3) The home license is:
- (a) Not transferable; and
 - (b) Valid only for the provider and address listed on the license.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10010, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10015 License—Adult family home—Compliance required. (1) The licensed adult family home must comply with all the requirements established in chapters 70.128, 70.129, 74.34 RCW and this chapter or other applicable laws and regulations; and

(2) The provider or entity representative is ultimately responsible for the operation of the adult family home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10015, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10020 License—Ability to provide care and services. The adult family home must have the understanding, ability, emotional stability and physical health suited to meet the personal and special care needs of vulnerable adults.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10020, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10025 License annual fee. (1) The license fee is fifty dollars per adult family home per year.

(2) The home must send the annual license fee to the department upon receipt of notice of fee due.

(3) If the department does not renew the license, the annual license fee is refundable.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10025, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10030 License capacity. (1) The department will only issue an adult family home license for more than one but not more than six residents.

(2) In determining the home's capacity, the department must consider the:

- (a) Structural design of the house;
- (b) Number and qualifications of staff;
- (c) Total number of people living in the home who require personal or special care, including:
 - (i) Children; and
 - (ii) Other household members;
- (d) The number of people for whom the home provides adult day care; and
- (e) The ability for the home to safely evacuate all people living in the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10030, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10035 License requirements—Multiple family home providers. To be licensed to operate more than one adult family home, the applicant must have:

(1) Evidence that the provider or entity representative has successfully completed the forty-eight hour residential care administrator's training to meet the related requirements of chapter 388-112 WAC.

(2) Operated an adult family home in Washington for at least one year without a significant violation of chapters 70.128, 70.129 or 74.34 RCW, this chapter or other applicable laws and regulations; and

(3) The ability to operate more than one home.

(4) The following plans for each home the applicant intends to operate:

(a) A twenty-four hour a day, seven day a week staffing plan;

(b) A plan for how the provider entity representative, or resident manager will manage the daily operations of each home; and

(c) A plan for emergencies, deliveries, staff and visitor parking.

(5) A credit history considered if the history relates to the ability to provide care and services.

(6) An applicant, entity representative or a qualified resident manager at each home who is responsible for the care of each resident at all times.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10035, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10040 License requirements—Provider or entity representative residence. (1) The adult family home provider or entity representative must:

(a) Live in the home; or

(b) Employ or contract with a qualified resident manager who lives in the home and is responsible for the care and services of each resident at all times; or

(c) Provide twenty-four hour staffing.

(2) Ensure that a qualified staff person who can make needed decisions is always present.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10040, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10045 Licensing—Certain state employees and employee household members—Prohibited. The department must not issue an adult family home license to employees or members of the employees' household of:

(1) Aging and disability services administration; or

(2) The department when the employee's duties include:

(a) Placement of persons in an adult family home; or

(b) Authorizing payments for any resident's care and services in an adult family home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10045, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10050 License—Relinquishment. (1) The adult family home must relinquish the adult family home license to the department:

(a) Within thirty days of the last resident leaving the home; or

(b) When the home moves all residents out of the home for purposes other than remodeling or construction.

(2) The department may revoke the license if the home does not:

(a) Relinquish the adult family home license; or

(b) Relinquish the adult family home license within the specified time frame.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10050, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10055 Application—Generally. (1) The applicant must send an application to the department for:

(a) An initial adult family home license;

(b) A change of ownership of the adult family home; or

(c) A change of the adult family home location or address.

(2) Prior to sending the application to the department, the applicant must ensure:

(a) The people listed on the application meet the minimum qualifications listed in WAC 388-76-10130 through 388-76-10145 as required; and

(b) After January 1, 2007, the provider and entity representative must successfully complete the department approved forty-eight hour adult family home administration and business planning class as required in chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10055, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10060 Application—Department orientation class—Required. (1) An applicant or any person who has not held an adult family home license within the last twelve months must attend a department approved orientation class before receiving an application form; and

(2) If an applicant has not obtained an adult family home license within one calendar year of submitting the application to the department the applicant must attend department orientation again.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10060, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10065 Application—Required information. To apply for a license, an applicant must:

(1) Provide all information required on the application form;

(2) Provide any additional information requested by the department; and

(3) Send the complete application form to the department.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10065, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10070 Application—Fee required. (1) The applicant must send a one hundred dollar fee with the application form:

(a) Fifty dollars of this fee is the application processing fee; and

(b) Fifty dollars is the annual license fee.

(2) The fifty dollar annual license fee will be returned to the applicant by the department if the application is withdrawn, voided or the license is denied.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10070, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10075 Application—Becomes void. The department must consider the application void when the applicant:

(1) Does not return information to the department within sixty calendar days of the department's first request for additional information for an incomplete application; or

(2) Has not obtained an adult family home license within one calendar year of first submitting the application to the department.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10075, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10080 Application—Coprovider. Couples considered legally married under Washington state law:

(1) May not apply for separate licenses for each spouse; and

(2) May apply jointly as coproviders.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10080, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10085 Application—Individual or coprovider. The applicant must include in the application a list of all facilities or homes in which the applicant or persons affiliated with the applicant, provided care and services to children or vulnerable adults within the last ten years.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10085, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10090 Application—Entity application. An entity submitting an application must:

(1) Include a list of all facilities or homes in which the applicant or persons affiliated with the applicant, managerial employee, or owner of five percent or more of the entity provided care and services to children or vulnerable adults within the last ten years;

(2) Designate an entity representative who:

(a) Is responsible for the daily operations of the adult family home;

(b) Will be considered the department's primary contact person; and

(c) May act as both the entity representative and the resident manager in only one home.

(3) Designate a qualified resident manager for the home if the entity representative is not the designated resident manager in subsection (2)(c) of this section.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10090, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10095 Application—Identification of landlord—Required. (1) Applicants must name the landlord of the building if the building to be used as an adult family home is leased, under contract, or rented and the landlord takes an active interest in the operation of the home.

(2) An active interest includes but is not limited to:

- (a) The charging of rent as a percentage of the business;
- (b) Assistance with start-up and/or operational costs;
- (c) Collection of resident fees;
- (d) Recruitment of residents;
- (e) Management oversight;
- (f) Assessment and/or negotiated care plan development of residents; or
- (g) The provision of personal or special care of residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10095, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10100 Application—Subject to review.

(1) Adult family home license applications are subject to review under this chapter.

(2) The department will not process an incomplete application and will return the application requesting the missing information.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10100, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10105 Application—Change of ownership. (1) A change of ownership of an adult family home requires both a new license application and a new license.

(2) A change of ownership occurs when there is a change in:

(a) The provider or entity representative ultimately responsible for the daily operational decisions of the home; or

(b) Control of an entity provider.

(3) Events which constitute a change of ownership include, but are not limited to:

(a) The form of legal organization of the provider is changed, such as when a provider forms:

(i) A partnership;

(ii) Corporation;

(iii) Association; or

(iv) A dissolution or merger of a licensed entity with another legal organization.

(b) The provider or entity representative transfers business operations and management responsibility to another party, whether there is a partial or whole transfer of adult family home real property and/or personal property assets.

(c) Two people are both licensed as a married couple to operate an adult family home and an event, such as a divorce or death results in only one person operating the home.

(d) An event dissolves the partnership, if the provider or entity representative is a business partnership.

(e) If the provider or entity representative is a corporation and the corporation:

(i) Is dissolved;

(ii) Merges with another corporation which is the survivor; or

(iii) Consolidates with one or more corporations to form a new corporation;

(iv) Whether by a single transaction or multiple transactions within a continuous twenty-four month period, transfers fifty percent or more of the stock to one or more:

(A) New or former stockholders; or

(B) Present stockholders each having less than five percent of the stock before the initial transaction.

(f) Any other event or combination of events which results in a substitution of or control of the provider or entity representative.

(4) The new owner:

(a) Must correct all deficiencies that exist at the time of the ownership change;

(b) Is subject to the provisions of chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations;

(c) Must obtain a new license from the department before the transfer of ownership; and

(d) Must not begin operation of the adult family home as the new owner, provider or entity representative until the department has granted the license.

(5) The home must notify each resident, in writing at least thirty days before the effective date of the ownership change.

(6) If a currently licensed provider or entity representative seeking to change ownership wants the department to give priority to processing an application to minimize or prevent disruption of residents that live in the existing home, the applicant must:

(a) Make the request to the department in writing, including the reason for changing the location of the home; and

(b) Explain how or why the reason for the change is beyond the control of the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10105, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10110 Application—Change of location or address. (1) A change of the adult family home location or address requires both a new license application and a new license.

(2) The home must not start operations of the home at a new location until the department has granted the license for the new location.

(3) The home must notify each resident or resident representative, in writing at least thirty days before the effective date of the change of the home location or address.

(4) If a currently licensed provider or entity representative, seeking to change the home location or address wants the department to give priority to processing an application to minimize or prevent the disruption of residents that live in the existing home, the applicant must:

(a) Make the request in writing, including the reason for changing the location of the home to the department; and

(b) Explain how or why the reason for change is beyond the control of the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10110, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10115 Granting or denying a license—Generally. In making a determination of whether to grant an adult family home license, the department must consider:

(1) Separately and jointly as applicants each person and entity named in an application, including each person or entity affiliated with the applicant;

(2) Information in the application;

(3) Other documents and information the department deems relevant which may include, but not be limited to:

(a) Inspection and complaint investigation findings in each facility or home in which the applicant, person affiliated with the applicant, or owner of five percent or more of the entity provided care or services to children or vulnerable adults; and

(b) Credit information.

(4) The history of each individual listed on the application for negative findings identified in WAC 388-76-10120 and 388-76-10125, including, but not limited to the following:

(a) Applicant;

(b) Person affiliated with the applicant;

(c) Entity representative;

(d) Caregiver;

(e) An owner who:

(i) Exercised daily control over the operations; or

(ii) Owns fifty-one percent or more of the entity.

(f) Any person who has unsupervised access to residents in the home; and

(g) Any person who lives in the home and is not a resident.

(5) Applicants who are licensed to care for children in the same home to determine if:

(a) It is necessary to allow a resident's child(ren) to live in the same home as the resident or allow a resident's child(ren) who turn eighteen to stay in the home;

(b) The applicant provides satisfactory evidence to the department of the home's ability to meet the needs of children and adults residing in the home; and

(c) The total number of persons receiving care and services in the home do not exceed the licensed capacity of the adult family home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10115, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10120 License—Must be denied. The department must deny a license if the department finds any person or entity unqualified as follows:

(1) Has a history of prior violations of chapter 70.128 RCW or any law regulating to residential care facilities within the past five years that resulted in revocation, suspension, or nonrenewal of a license or contract with the department;

(2) When providing care or services to children or vulnerable adults:

(a) Has been found to be in significant noncompliance with federal or state regulations; or

(b) Had a license for the care of children or vulnerable adults suspended or revoked.

(3) For a period of twenty years after a provider surrendered or relinquished an adult family home license after notification of the department's intention to deny, suspend, not renew or revoke, in lieu of appealing the department's action;

(4) Been enjoined from operating a facility for the care and services of children or adults;

(5) A stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, final order issued by a disciplining authority or final decision by any federal or state agency or department, a court of law, or entered into a state registry or department or agency list with a find-

ing of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW;

(6) Had a revocation or suspension of a license for the care of children or adults;

(7) Had a revocation, cancellation, suspension or nonrenewal of:

(a) A Medicaid or Medicare provider agreement by the contracting agency; or

(b) Any agreement with a public agency for the care and treatment of children or vulnerable adults, when the action was taken by the public agency.

(8) Been convicted of any crime listed in RCW 43.43.830 or 43.43.842;

(9) Been found by a court:

(a) In a protection proceeding under chapter 74.34 RCW to have abandoned, neglected, abused, or financially exploited a vulnerable adult; or

(b) In a domestic relations proceeding under Title 26 RCW to have sexually or physically abused, neglected or exploited any minor.

(10) Been found in any final decision issued by a disciplinary board to have:

(a) Sexually or physically abused, neglected or exploited any minor or a person with a developmental disability; or

(b) Abandoned, abused, neglected or financially exploited any vulnerable adult.

(11) Been found in any final decision by any federal or state agency or department to have abandoned, neglected, abused or financially exploited a vulnerable adult;

(12) Found in any dependency action under RCW 13.34.030 (5)(b) to have sexually or physically abused, neglected or exploited any minor;

(13) The home is currently licensed:

(a) As a boarding home; or

(b) To provide care for children in the same home, unless:

(i) It is necessary in order to allow a resident's child(ren) to live in the same home as the resident or to allow a resident who turns eighteen to remain in the home;

(ii) The applicant provides satisfactory evidence to the department of the home's capacity to meet the needs of children and adults residing in the home; and

(iii) The total number of persons receiving care and services in the home does not exceed the number permitted by the licensed capacity of the home.

(14) If the provider or entity representative has not successfully completed a department-approved forty-eight hour adult family home administration and business planning class.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10120, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10125 License—May be denied. The department may deny a license if the department finds any person or entity unqualified as follows:

(1) Been convicted of a crime:

(a) As defined under RCW 43.43.830 or 43.43.842;

(b) Relating to financial exploitation as defined under RCW 43.43.830 or 43.43.842;

(c) A felony against a person if the conviction reasonably relates to the competency of the person to own or operate an adult family home;

(d) Involving a firearm used in the commission of a felony or in any act of violence against a person; or

(e) Engaged in illegally selling or distributing drugs illegal use of drugs or excessive use of alcohol within the past five years without the evidence of rehabilitation.

(2) Found by a court in a protection proceeding under chapter 74.34. RCW to have abandoned, abused, neglected, or financially exploited a vulnerable adult;

(3) Found in a final decision issued by a disciplinary board to have sexually or physically abused, neglected or exploited any minor person or a person with a developmental disability or to have abused or financially exploited any vulnerable adult;

(4) Found in any dependency action under RCW 13.34.030(5) to have sexually abused, neglected or exploited any minor or to have physically abused any minor;

(5) Found in a court in a domestic relations proceeding under Title 26 RCW to have:

(a) Sexually abused, neglected or exploited any minor or to have physically abused any minor; or

(b) Committed an act of domestic violence toward a family or household member.

(6) Had sanction, corrective, or remedial action taken by federal, state, county, or municipal officials or safety officials related to the care or treatment of children or vulnerable adults;

(7) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(8) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached to the application or in any matter under investigation by the department;

(9) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(10) Willfully prevented or interfered with or failed to cooperate with any inspection, investigation or monitoring visit made by the department;

(11) Failed or refused to comply with:

(a) A condition imposed on a license or a stop placement order; or

(b) The applicable requirements of chapters 70.128, 70.129, 74.34 RCW or this chapter.

(12) Misappropriated property of a resident;

(13) Denied a license or license renewal to operate a facility that was licensed to care for children or vulnerable adults;

(14) Exceeded licensed capacity in the operation of an adult family home;

(15) Operated a facility for the care of children or adults without a license or revoked license;

(16) Relinquished or returned a license in connection with the operation of any facility for the care of children or adults, or did not seek license renewal following written notification of the licensing agency's intention of denial, suspension, cancellation or revocation of a license;

(17) Had resident trust funds or assets of an entity providing care to children or vulnerable adults seized by the

Internal Revenue Service or a state entity for failure to pay income or payroll taxes;

(18) Failed to meet financial obligations as the obligations fell due in the normal course of business, thereby impeding the ability to provide care and services to residents;

(19) Refused to permit authorized department representatives to interview residents or to have access to resident records or home;

(20) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties; or

(21) Found to be in noncompliance with the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter or other applicable laws and regulations.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10125, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10130 Qualifications—Provider, entity representative and resident manager. The adult family home must ensure that the provider, entity representative and resident manager have the following minimum qualifications:

(1) Be twenty-one years of age or older;

(2) Have a United States high school diploma or general education development certificate, or any English translated government document of the following:

(a) Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction;

(b) Graduation from a foreign college, foreign university, or United States community college with a two-year diploma, such as an Associate's degree;

(c) Admission to, or completion of course work at a foreign or United States college or university for which credit was awarded;

(d) Graduation from a foreign or United States college or university, including award of a Bachelor's degree;

(e) Admission to, or completion of postgraduate course work at, a United States college or university for which credits were awarded, including award of a Master's degree; or

(f) Successful passage of the United States board examination for registered nursing, or any professional medical occupation for which college or university education was required.

(3) Meet the department's training requirements of chapter 388-112 WAC;

(4) Have good moral and responsible character and reputation;

(5) Be literate in the English language, or meet alternative requirements by assuring that a person is on staff and available at the home who is:

(a) Able to communicate or make provisions for communicating with the resident in his or her primary language; and

(b) Capable of understanding and speaking English well enough to be able to respond appropriately to emergency situations and be able to read, understand and implement resident negotiated care plans.

(6) Be able to carry out the management and administrative requirements of chapters 70.128, 70.129 and 74.34 RCW, this chapter and other applicable laws and regulations;

(7) Have completed at least three hundred and twenty hours of successful direct care experience obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home;

(8) Have no criminal convictions listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation;

(9) Obtain and keep valid cardiopulmonary resuscitation (CPR) and first-aid card or certificate as required in chapter 388-112 WAC; and

(10) Have tuberculosis screening to establish tuberculosis status per this chapter.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10130, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10135 Qualifications—Caregiver. The adult family home must ensure each caregiver has the following minimum qualifications:

(1) Be eighteen years of age or older;

(2) Have a clear understanding of the caregiver job responsibilities and knowledge of each resident's negotiated care plan to provide care specific to the needs of each resident;

(3) Have basic communication skills to:

(a) Be able to communicate or make provisions to communicate with the resident in his or her primary language;

(b) Understand and speak English well enough to:

(i) Respond appropriately to emergency situations; and

(ii) Read, understand and implement resident negotiated care plans.

(4) Meet the department's training requirements of chapter 388-112 WAC;

(5) Have no criminal convictions listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation;

(6) Have a current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter 388-112 WAC; and

(7) Have tuberculosis screening to establish tuberculosis status per this chapter.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10135, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10140 Qualifications—Students—Volunteers. The adult family home must ensure that students and volunteers meet the following minimum qualifications:

(1) Be eighteen years old or older;

(2) Meet the department's training requirements of chapter 388-112 WAC;

(3) Have no criminal convictions listed in RCW 43.43.830 and 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation; and

(4) Tuberculosis screening to establish tuberculosis status per this chapter.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10140, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10145 Qualifications—Licensed nurse as provider, entity representative or resident manager. The adult family home must ensure that a licensed nurse who is a provider, entity representative or resident manager has:

(1) No criminal convictions listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation; and

(2) A current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10145, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10150 Qualifications—Assessor. (1) The adult family home must ensure that an assessor, except for an authorized department case manager, performing an assessment for any resident meets the following qualifications:

(a) A master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or

(b) A bachelor's degree in social services, human services, behavioral sciences or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or

(c) Have a valid Washington state license to practice as a nurse under chapter 18.79 RCW and three years of clinical nursing experience; or

(d) Is currently a licensed physician, including an osteopathic physician, in Washington state.

(2) The home must ensure that an assessor who meets the requirements of subsections (1)(a), (b), or (c) of this section does not have unsupervised access to any resident unless the assessor has:

(a) A current criminal history background check; and

(b) Has not been convicted of any crime listed in RCW 43.43.830 or 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10150, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10155 Unsupervised access to vulnerable adults—Prohibited. The adult family home must not allow the following persons to have unsupervised access to residents until the home receives successful results from the criminal history background check:

(1) Caregivers;

(2) Staff;

(3) Volunteers or students acting as a caregiver; and

(4) Household members over the age of eleven.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10155, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10160 Criminal history background check—Required. To assist in determining the character, suitability, and competence of a potential employee and before the adult family home employs, directly or by contract, a resident manager, entity representative or caregiver, or accepts as a caregiver any volunteer or student, or allows a

household member over the age of eleven unsupervised access to residents, the home must:

(1) Require the person to complete the residential care services background inquiry form which includes:

(a) A disclosure statement; and

(b) A statement authorizing the home, the department, and the Washington state patrol to conduct a background inquiry.

(2) Verbally inform the person:

(a) That he or she may ask for a copy of the background inquiry result; and

(b) Of the inquiry result within ten days of receiving the result.

(3) Send the information to the department and any additional documentation and information as requested by the department to satisfy the requirements of this section; and

(4) Notify the appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10160, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10165 Criminal history background check—Valid for two years. (1) A background inquiry result is valid for two years from the date conducted;

(2) The adult family home must have a valid criminal history background check for all persons in the home who may have unsupervised access to any resident; and

(3) The home must submit, receive and keep the results of the check every two years.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10165, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10170 Criminal history background check—Information—Confidentiality—Use restricted. The adult family home must:

(1) Establish and implement procedures that ensure:

(a) All disclosure statements background inquiry applications, responses, related information, and all copies are kept in a confidential and secure manner;

(b) All background inquiry results and disclosure statements are used for employment purposes only;

(c) Background inquiry results and disclosure statements are not disclosed to any person except:

(i) The person about whom the home made the disclosure or background inquiry;

(ii) Authorized state and federal employees; and

(iii) The Washington state patrol auditor.

(2) Keep a record of inquiry results for eighteen months after the date an employee either quits or is terminated.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10170, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10175 Employment—Conditional—Pending results. An adult family home may conditionally employ a person pending the result of a background inquiry, provided the home:

(1) Asks the individual if they have been convicted of a crime listed under RCW 43.43.830 or 43.43.842 and the individual denies they have a conviction;

(2) Requests the background inquiry within seventy-two hours of the conditional employment;

(3) Does not allow, the conditionally hired person, to have unsupervised access to any resident without direct supervision; and

(4) Ensures the individual is competent and receives the necessary training to perform assigned tasks and meets the staff training requirements in chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10175, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10180 Employment—Certain criminal history—Prohibited. The adult family home must not employ any person, directly or by contract, or accept as a volunteer or student any person who may have unsupervised access to residents, or allow a household member over the age of eleven unsupervised access to any resident if the person or background inquiry discloses that the person has a history of:

(1) A stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, final order issued by a disciplining authority or final decision by any federal or state agency or department, a court of law, or entered into a state registry or department or agency list with a finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW; or

(2) Convicted of a crime against persons as defined under RCW 43.43.830 or 43.43.842.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10180, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10185 Employment—Certain criminal history—Permitted. (1) Nothing in this section may be interpreted to require the employment of any person against the judgment of the provider or entity representative.

(2) The adult family home may choose to employ a person if the person has one or more convictions for a past offense and the offense was:

(a) Simple assault, assault in the fourth degree and three or more years has passed between the most recent conviction and the date of the application for employment;

(b) Prostitution and three or more years has passed between the most recent conviction and the date of the application for employment;

(c) Theft in the third degree and three or more years has passed between the most recent conviction and the date of the application for employment;

(d) Theft in the second degree and five or more years has passed between the most recent conviction and the date of the application for employment; or

(e) Forgery and five or more years has passed between the most recent conviction and the date of the application for employment.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10185, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10190 Adult family home—Compliance with regulations—Required. The adult family home must comply with:

(1) This chapter;

(2) Chapters 70.128, 70.129 and 74.34 RCW; and

(3) Other applicable state and federal laws.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10190, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10195 Adult family home—Staff—Generally. The adult family home must ensure:

(1) Enough staff is available in the home to meet the needs of each resident if residents are in the home or not, except as per WAC 388-76-10200;

(2) Staff are readily available to meet resident needs if the home takes the resident out to another location and the resident negotiated care plan does not indicate it is safe for the resident to be left unattended for a specific time period; and

(3) All staff are skilled and able to do the tasks assigned to meet the needs of each resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10195, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10200 Adult family home—Staff—Availability—Contact information. In addition to other licensing requirements for staff availability, the adult family home must:

(1) Designate an experienced, capable staff member of responding on behalf of the provider or entity representative:

(a) By phone or pager;

(b) At all times including:

(i) When no residents are present in the home; and

(ii) When the provider entity representative and residents are on vacation or away from the home.

(2) Give residents the telephone or pager number for the contact required in subsection (1) of this section;

(3) Ensure the provider, entity representative or resident manager is readily available to:

(a) Each resident;

(b) Residents' representatives;

(c) Caregivers; and

(d) Authorized state staff.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10200, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10205 Medicaid or state funded residents. When the adult family home accepts Medicaid or state funded residents, the home must follow the terms and conditions of the department contract and chapter 388-105 WAC.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10205, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10210 Resident relocation due to closure. When an adult family home chooses to voluntarily close, the home must:

(1) Notify the following in writing of the closure at least thirty days before the home closes:

(a) The department;

(b) Each resident; and

(c) Each resident's representative.

(2) Develop, organize, and carry out a discharge plan that meets the needs of each resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10210, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10215 Resident funds—Protection, liquidation or transfer. (1) The adult family home must meet the requirements of RCW 70.129.040 to protect any funds the resident may have deposited with the adult family home.

(2) If a deceased resident had some of his or her adult family home care paid for by the department, then the home must:

(a) Send the final accounting and funds payable to:

Secretary, Department of Social and Health Services
Office of Financial Recovery
Estate Recovery Unit

(b) Include with the final accounting required in subsection (2)(a) of this section:

(i) The deceased resident's name; and
(ii) The deceased resident's Social Security number.

(3) When a resident is missing from the home, in addition to other licensing requirements, the home must make a reasonable effort to find the missing resident before transferring resident funds to the department of revenue as per subsection (4) of this section.

(4) The adult family home must notify the department of revenue of abandoned property when:

(a) A resident is missing from the home for more than ninety days; and

(b) The missing resident:

(i) Gave money to the home to manage or for safekeeping;

(ii) Does not have a legal guardian;

(iii) Did not appoint a power of attorney to handle his or her financial affairs;

(iv) Did not name a family member to act on the resident's behalf; and

(v) Did not have his or her care paid for by the department.

(5) The home must send any money received from the missing resident, to the department of revenue:

(a) According to chapter 63.29 RCW;

(b) Within twenty days of notifying the department of revenue per subsection (2) of this section.

(6) Before the adult family home changes its owner, the home must:

(a) Give each resident a written statement that accounts for any personal funds held by the home;

(b) Give the prospective adult family home owner a written statement that accounts for all of the residents' funds that home will transfer to the new adult family home owner; and

(c) Get a written receipt of the transferred residents' funds from the new adult family home owner.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10215, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10220 Incident log. The adult family home must keep a log of:

(1) Alleged or suspected instances of abandonment, neglect, abuse or financial exploitation;

(2) Accidents or incidents affecting a resident's welfare; and

(3) Any injury to a resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10220, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10225 Reporting requirement. (1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation or abandonment of a resident:

(i) According to chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number; and

(iii) To the local law enforcement agency when required by RCW 74.34.035.

(b) Report the following to the department by calling the complaint toll-free hotline number:

(i) Any actual or potential event requiring any resident to be evacuated;

(ii) Conditions that threaten the provider's or entity representative's ability to continue to provide care or services to each resident; and

(iii) A missing resident.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(b) The resident's representative, if one exists;

(c) The resident's physician;

(d) Other appropriate professionals working with the resident;

(e) Persons identified in the negotiated care plan; and

(f) The resident's case manager if the resident is a department client.

(3) Whenever an outbreak of suspected food poisoning or communicable disease occurs, the adult family home must notify:

(a) The local public health officer; and

(b) The department's complaint toll-free hotline number.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10225, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10230 Pets. The adult family home must ensure any animal visiting or living on the premises:

(1) Does not compromise any resident rights, preferences or medical needs;

(2) Has a suitable temperament, is clean and healthy, and otherwise poses no significant health or safety risks to any resident, staff, or visitors; and

(3) Has proof of regular immunizations.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10230, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10235 Guardianship. The adult family home may be a resident's guardian if:

(1) A court has appointed the home to be the guardian under chapter 11.88 RCW; and

(2) The home has petitioned the court in writing according to RCW 11.92.040(6) to:

(a) Inform the court:

(i) The home provides care for the resident in the home;

(ii) The fees the home is paid to care for the resident, the home's duties, and the types of care provided to the resident for those fees; and

(iii) Why the guardianship fees would not be duplicative of the fees paid.

(b) Request the court to direct payment to the home from the resident's funds for the resident's care, maintenance and education.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10235, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10240 Durable power of attorney for health care or financial decisions. The adult family home must not allow a provider, entity representative, owner, administrator, or employees of the home to act as a resident's attorney in fact, according to chapter 11.94 RCW, unless the provider, entity representative, owner, administrator, or employee is the resident's:

- (1) Spouse;
- (2) Adult child; or
- (3) Brother or sister.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10240, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10245 Resident self-determination—Health care decision making. The adult family home must provide care and services consistent with the federal patient self-determination act and other statutes related to a resident legal representative and health care decision making, including but not limited to:

- (1) Chapter 7.70 RCW;
- (2) Chapter 70.122 RCW;
- (3) Chapter 11.88 RCW;
- (4) Chapter 11.92 RCW; and
- (5) Chapter 11.94 RCW.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10245, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10250 Medical emergencies—Contacting emergency medical services—Required. (1) The adult family home must develop and implement policies and procedures which require immediate contact of the local emergency medical services when a resident has a medical emergency. This requirement applies:

(a) Unless the caregiver, present at the time of the emergency, is a licensed physician or registered nurse acting within his or her scope of practice;

(b) Whether or not:

(i) Any order exists directing medical care for the resident;

(ii) The resident has provided an advance directive for medical care; or

(iii) The resident has expressed any wishes involving medical care.

(2) If available, the home must immediately give arriving emergency medical services personnel a copy of:

(a) Any order that exists directing medical care for the resident; and

(b) The resident's advance directive for medical care.

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(3) The home must inform the resident of the requirements in this section.

(4) The home is not required to contact emergency medical services when a resident is receiving hospice care by a licensed hospice agency and the:

- (a) Emergency relates to the expected hospice death; and
- (b) Situation is monitored by the hospice agency.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10250, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10255 Infection control. The adult family home must develop and implement an infection control system that:

(1) Uses nationally recognized infection control standards;

(2) Emphasizes frequent hand washing and other means of limiting the spread of infection;

(3) Follows the requirements of chapter 49.17 RCW, Washington Industrial Safety and Health Act to protect the health and safety of each resident and employees; and

(4) Directs all staff to:

(a) Dispose of razor blades, syringes, and other sharp items in a manner that will not risk the health and safety of residents, staff, other persons residing in the home or the public; and

(b) Use all disposable and single-service supplies and equipment only one time as specified by the manufacturer.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10255, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10260 Communicable disease—Preventing spread. If the adult family home suspects anyone working or living in the home has or may have a communicable disease, the home must implement nationally recognized infection control measures.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10260, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10265 Tuberculosis—Testing—Required. (1) The adult family home must develop and implement a system to ensure the following persons have tuberculosis testing within three days of employment:

(a) Provider;

(b) Entity representative;

(c) Resident manager;

(d) Caregiver;

(e) Staff; and

(f) Any student or volunteer providing any resident care and services.

(2) For the purposes of the tuberculosis sections "person" means the people listed in this section as required to have tuberculosis testing.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10265, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10270 Tuberculosis—Testing method—Required. The adult family home must ensure that all tuberculosis testing is done through a nationally recognized testing method such as by intradermal (Mantoux) administration or a TB Gold Test and the test result is read:

- (1) Within forty-eight to seventy-two hours of the test; and
- (2) By a trained professional.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10270, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10275 Tuberculosis—No skin testing.

The adult family home is not required to have a person tested for tuberculosis if the person has:

- (1) A documented history of a previous positive test, ten or more millimeters in duration; or
- (2) Documented evidence of:
 - (a) Adequate therapy for active disease; or
 - (b) Preventive therapy of infection.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10275, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10280 Tuberculosis—One step testing.

The adult family home is only required to have a person take a one-step skin test if the person has any of the following:

- (1) A positive result from the person's first skin test—A person who has a positive result from an initial first step test should not have a second test;
- (2) A documented history of a negative result from previous two step testing; or
- (3) A documented negative result from one step testing in the previous twelve months.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10280, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10285 Tuberculosis—Two step testing.

Unless the person meets the requirement for having no skin testing or only a one step skin test, the adult family home must ensure that each person has the following two-step testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test; except
- (3) A two-step test is not required for the TB Gold Test which is only a one-step test.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10285, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10290 Tuberculosis—Positive skin reaction. The adult family home must ensure that a person with a positive reaction to tuberculosis skin testing has a chest X ray within seven days and follows the recommendation of health care officials.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10290, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10295 Tuberculosis—Negative skin reaction. The adult family home may be required by the public health official or licensing authority to ensure that persons with negative test results have follow-up skin testing in certain circumstances, such as:

- (1) After exposure to active tuberculosis;
- (2) When tuberculosis symptoms are present; or
- (3) For periodic testing as determined by health official.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10295, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10300 Tuberculosis—Declining a test.

The adult family home may accept a signed statement from a person who has reason to decline skin testing; if:

- (1) The signed statement includes the reason for declining; and
- (2) Additional evidence is provided to support the reason.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10300, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10305 Tuberculosis—Reporting positive skin reactions—Required. The adult family home must:

- (1) Report any person with tuberculosis symptoms or a positive chest X ray to the appropriate public health authority; and
- (2) Follow the infection control and safety measures ordered by the public health authority, the person's personal physician, or other licensed health care professional.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10305, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10310 Tuberculosis—Skin test records.

The adult family home must:

- (1) Keep the records of tuberculosis test results, reports of X-ray findings, and physician or public health orders and waivers;
- (2) Make them readily available to the appropriate health authority and licensing agency; and
- (3) Keep them for eighteen months after the date an employee either quits or is terminated.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10310, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10315 Resident record—Required. The adult family home must:

- (1) Create, maintain, and keep records for residents in the home where the resident lives and ensure that the records:
 - (a) Contain enough information so home can provide the needed care and services to each resident;
 - (b) Be in a format useful to the home;
 - (c) Be kept confidential so that only authorized persons see their contents;
 - (d) Are only released to the following persons:
 - (i) A health care institution;
 - (ii) When requested by the law;
 - (iii) To department representatives; and
 - (iv) To the resident;
 - (e) Be protected to prevent loss, alteration or destruction and unauthorized use;
 - (f) Be kept for three years after the resident leaves the home or death of the resident;
 - (g) Be available so that department staff may review them when requested; and
 - (h) Provide access to the resident to review their record and obtain copies of their record at a reasonable cost.
- (2) Ensure staff has access to the parts of residents' records needed by staff to provide care and services; and

(3) Allow representatives of the long-term care ombudsman access to a resident record if approved by the resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10315, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10320 Resident record—Content. The adult family home must ensure that each resident record contains, at a minimum, the following information:

- (1) Identifying information about the resident;
- (2) The name, address and telephone number of the resident's:
 - (a) Representative;
 - (b) Health care providers;
 - (c) Significant family members identified by the resident; and
 - (d) Other individuals the resident wants involved or notified.
- (3) Current medical history;
- (4) The resident assessment information;
- (5) The preliminary service plan;
- (6) The negotiated care plan;
- (7) List of resident medications;
- (8) The resident's Social Security number;
- (9) When the resident was:
 - (a) Admitted to the home;
 - (b) Absent from the home; and
 - (c) Discharged from the home.
- (10) A current inventory of the resident's personal belongings dated and signed by:
 - (a) The resident; and
 - (b) The adult family home.
- (11) Financial records.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10320, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10325 Resident record—Legal documents—If available. When available, the adult family home must obtain copies of the following legal documents for the resident's records:

- (1) Any powers of attorney granted by the resident, including for health care decision making and financial; and
- (2) Court order of guardianship for the resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10325, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10330 Resident assessment. The adult family home must:

- (1) Obtain a new written assessment before admitting a resident to the home;
- (2) Not admit a resident without an assessment except in cases of a genuine emergency;
- (3) Ensure the assessment contains all of the information required in WAC 388-76-10335 unless the assessor can not:
 - (a) Obtain an element of the required assessment information; and
 - (b) The assessor documents the attempt to obtain the information in the assessment.
- (4) Be knowledgeable about the needs and preferences of each resident documented in the assessment.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10330, filed 10/16/07, effective 1/1/08.]

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WAC 388-76-10335 Resident assessment topics. (1)

For the purposes of this section, "body care" means:

(a) How the resident performs with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet; and

(b) Dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC.

(2) Body care includes:

(a) Foot care if the resident is diabetic or has poor circulation; or

(b) Changing bandages or dressings when sterile procedures are required.

(3) The adult family home must ensure that each resident's assessment includes the following minimum information:

(a) Recent medical history;

(b) Current prescribed medications, and contraindicated medications, including but not limited to, medications known to cause adverse reactions or allergies;

(c) Medical diagnosis reported by the resident, the resident representative, family member, or by a licensed medical professional;

(d) Medication management:

(i) The ability of the resident to be independent in managing medications;

(ii) The amount of medication assistance needed;

(iii) If medication administration is required; or

(iv) If a combination of the elements in (i) through (iii) above is required.

(e) Food allergies or sensitivities;

(f) Significant known behaviors or symptoms that may cause concern or require special care, including:

(i) The need for and use of medical devices;

(ii) The refusal of care or treatment; and

(iii) Any mood or behavior symptoms that the resident has had within the last five years.

(g) Cognitive status, including an evaluation of disorientation, memory impairment, and impaired judgment;

(h) History of depression and anxiety;

(i) History of mental illness, if applicable;

(j) Social, physical, and emotional strengths and needs;

(k) Functional abilities in relationship to activities of daily living including:

(i) Eating;

(ii) Toileting;

(iii) Walking;

(iv) Transferring;

(v) Positioning;

(vi) Specialized body care;

(vii) Personal hygiene;

(viii) Dressing; and

(ix) Bathing.

(l) Preferences and choices about daily life that are important to the resident, including but not limited to:

(i) The food that the resident enjoys;

(ii) Meal times; and

(iii) Sleeping and nap times.

(m) Preferences for activities; and

(n) A preliminary service plan.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10335, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10340 Preliminary service plan. The adult family home must ensure that each resident has a preliminary service plan that includes:

- (1) The resident's specific problems and needs identified in the assessment;
- (2) The needs for which the resident chooses not to accept or refuses care or services;
- (3) What the home will do to ensure the resident's health and safety related to the refusal of any care or service;
- (4) Resident defined goals and preferences; and
- (5) How the home will meet the resident's needs.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10340, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10345 Assessment—Qualified assessor—Required. The adult family home must ensure the person performing resident assessments is:

- (1) A qualified assessor; or
- (2) For a resident who receives care and services paid for by the department, an authorized department case manager.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10345, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10350 Assessment—Updates required. The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

- (1) When there is a significant change in the resident's physical or mental condition;
- (2) When the resident's negotiated care plan no longer reflects the resident's current status, needs and preferences;
- (3) At the resident's request or at the request of the resident's representative; or
- (4) At least every twelve months.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10350, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary service plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

- (1) A list of the care and services to be provided;
- (2) Identification of who will provide the care and services;
- (3) When and how the care and services will be provided;
- (4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;
- (5) The resident's activities preferences and how the preferences will be met;
- (6) Other preferences and choices about issues important to the resident, including, but not limited to:
 - (a) Food;
 - (b) Daily routine;
 - (c) Grooming; and

(d) How the home will accommodate the preferences and choices.

(7) If needed, a plan to:

- (a) Follow in case of a foreseeable crisis due to a resident's assessed needs;
- (b) Reduce tension, agitation and problem behaviors;
- (c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;
- (d) Respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal;
- (8) Identification of any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident;
- (9) A statement of the ability for resident to be left unattended for a specific length of time; and
- (10) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10355, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10360 Negotiated care plan—Timing of development—Required. The adult family home must ensure the negotiated care plan is developed and completed within thirty days of the resident's admission.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10360, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10365 Negotiated care plan—Implementation—Required. The adult family home must implement each resident's negotiated care plan.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10365, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10370 Negotiated care plan—Persons involved in development. The adult family home must involve the following people in developing the negotiated care plan:

- (1) The resident, to the greatest extent he or she can participate;
- (2) The resident's family, if approved by the resident;
- (3) The resident's representative, if the resident has a representative;
- (4) Professionals involved in the care of the resident;
- (5) Other individuals the resident wants included; and
- (6) The department case manager, if the resident is receiving care and services paid for by the department.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10370, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10375 Negotiated care plan—Signatures—Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

- (1) Resident; and
- (2) Adult family home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10375, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10380 Negotiated care plan—Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

- (1) After an assessment for a significant change in the resident's physical or mental condition;
- (2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;
- (3) At the request of the resident or the resident representative; or
- (4) At least every twelve months.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10380, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10385 Negotiated care plan—Copy to department case manager—Required. When the resident's services are paid for by the department, the adult family home must give the department case manager a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10385, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10390 Admission and continuation of services. The adult family home must only admit or continue to provide services to a person when:

- (1) The home can safely and appropriately meet the assessed needs and preferences of the person:
 - (a) With available staff; and
 - (b) Through reasonable accommodation.
- (2) Admitting the resident does not negatively affect the ability of the home to:
 - (a) Meet the needs and does not endanger the safety of other residents; or
 - (b) Safely evacuate all people in the home during an emergency.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10390, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10395 Emergency admissions. (1) The adult family home may only admit a resident to the home without an assessment or a preliminary service plan if a true emergency exists.

(2) To establish that a true emergency exists, the home must verify that the resident's life, health or safety is at serious risk due to circumstances in the resident's current place of residence or harm to the resident has occurred.

(3) After establishing that a true emergency exists, the home must:

(a) Ensure the assessment and preliminary service plan are completed within five working days after admitting the resident, if the resident pays for services with private funds; or

(b) Obtain approval from an authorized department case manager before admission if the resident's care and services are paid by the department; and

(c) If approval is obtained verbally, document the time, date, and name of the case manager who gave approval.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10395, filed 10/16/07, effective 1/1/08.]

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WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(1) The care and services identified in the negotiated care plan.

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10400, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10405 Nursing care. If the adult family home identifies that a resident has a need for nursing care and the home is not able to provide the care per chapter 18.79 RCW, the home must:

(1) Contract with a nurse currently licensed in the state of Washington to provide the nursing care and service; or

(2) Hire or contract with a nurse to provide nurse delegation.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10405, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10410 Laundry services. The adult family home must:

(1) Provide laundry services as needed; and

(2) Launder sheets and pillowcases weekly or more often if soiled.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10410, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10415 Food services. The adult family home must:

(1) Ensure the provider, entity representative and all staff meet the safe food handling training requirements of chapter 388-112 WAC; and

(2) Serve meals:

(a) In the home where each resident lives; and

(b) That accommodate each resident's:

(i) Preferences;

(ii) Food allergies and sensitivities;

(iii) Caloric needs;

(iv) Cultural and ethnic background; and

(v) Physical condition that may make food intake difficult such as being hard for the resident to chew or swallow.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10415, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10420 Meals and snacks. The adult family home must:

- (1) Serve at least three meals:
 - (a) In each twenty-four hour period;
 - (b) At regular times comparable to normal meal times in the community; and
 - (c) That meet the nutritional needs of each resident.
- (2) Make nutritious snacks available to residents:
 - (a) Between meals; and
 - (b) In the evening.
- (3) Get input from residents in meal planning and scheduling;
- (4) Serve nutrient concentrates, supplements, and modified diets only with written approval of the resident's physician;
- (5) Only serve pasteurized milk; and
- (6) Process any home-canned foods served in the home, according to the latest guidelines of the county cooperative extension service.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10420, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10425 Off-site food preparation. The adult family home must ensure:

- (1) Persons preparing food, at a location separate from the home, have a current food handler's permit issued by the department of health;
- (2) Prepared food transported to the home is in airtight containers; and
- (3) Food stays at the appropriate and safe temperature:
 - (a) During transportation; and
 - (b) When served.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10425, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10430 Medication system. (1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

- (a) Assessment indicates the amount of medication assistance needed by the resident;
 - (b) Negotiated care plan identifies the medication service that will be provided to the resident;
 - (c) Medication log is kept current as required in WAC 388-76-10475;
 - (d) Receives medications as required.
- (3) Records are kept which include a current list of prescribed and over-the-counter medications including name, dosage, frequency and the name and phone number of the practitioner as needed.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10430, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10435 Medication refusal. (1) Each resident has the right to refuse to take medications.

(2) If the adult family home is assisting with or administering a resident's medications and the resident refuses to take or does not receive a prescribed medication:

(a) The home must notify the resident's practitioner; unless

(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal.

(3) If the home becomes aware that a resident who self-administers, or takes their own medications, refuses to take a prescribed medication:

(a) The home must notify the practitioner; unless

(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10435, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10440 Medication—Assessment—Identification of amount of assistance needed when taking medications. (1) The adult family home must:

(a) Ensure each resident assessment identifies the amount of assistance the resident needs when taking medications; and

(b) Let the practitioner know when the following may affect the resident's ability to take their medications:

- (i) Resident's physical or mental limitations; and
- (ii) The setting or environment where the resident lives.

(2) The amount of assistance needed by a resident when taking their medications is as follows:

(a) *Independent self-administration* is when the resident does not need help taking medications and is able to directly take medications by eating or drinking, inhaling, by shot, through the skin or other means;

(b) *Self-administration with assistance*, as described in chapter 246-888 WAC, is when a resident is assisted in taking their medication by a nonpractitioner; and

(c) *Medication administration* is when medications are administered to the resident by a person legally authorized to do so, such as but not limited to a physician, nurse or pharmacist or through nurse delegation.

(3) The home must contact the resident's practitioner who will decide if a reassessment is necessary when:

(a) The resident has a change in the health status, medications, physical or mental limitations, or environment that might change the resident's need for medication assistance; or

(b) There is a need for a resident to have more than one type of medication assistance.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10440, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10445 Medication—Independent—Self-administration. The adult family home must ensure residents who have medication assistance assessed as independent self-administration:

(1) Administer their own medications; and

(2) Are allowed to keep their prescribed and over-the-counter medications securely locked in either their room or

another agreed upon area if documented in the resident negotiated care plan.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10445, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10450 Medication—Self-administration with assistance. (1) For the purposes of this section "enabler" means a physical device used to facilitate a resident's self-administration of a prescribed or over-the-counter medication. Physical devices include, but are not limited to a medicine cup, glass, cup, spoons, bowl, prefilled syringes, syringes used to measure oral liquids, specially adapted table surfaces, drinking straw, piece of cloth, and the resident's hand.

(2) The adult family home must ensure that the resident can:

(a) Put the medication into their own mouth; or

(b) Apply, inject, or instill the medications.

(3) The home must:

(a) Provide set-up assistance just before the resident takes or applies the medication; or

(b) Only give oral medications through a gastrostomy or "g-tube" when ordered by the practitioner; and

(c) Ensure the resident is aware they are taking a medication, however the resident does not have to name the medication, effects or side effects.

(4) Self-administration with assistance:

(a) Does not include shots or intravenous medications as defined in WAC 246-888-020, except for a prefilled insulin syringe;

(b) May include steadying or guiding a resident's hand while applying or instilling medications such as ointments, eye, ear and nasal preparations, but does not include the practice of "hand-over-hand" (total physical assistance) administration;

(c) May include transferring the medications from one container to another to make a single dose such as pouring a liquid from the medication container to a calibrated spoon or measuring cup;

(d) May include reminding or coaching the resident to take their medication;

(e) Does not include direct assistance with intravenous and injectable medications except the home may carry a prefilled insulin syringe which the resident can administer;

(f) May include using an enabler; and

(g) Could include delivering a prefilled insulin syringe to the resident if the resident independently self-administers the injection per WAC 246-888-020.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10450, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10455 Medication—Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(1) Performed by a person as defined in chapter 69.41 RCW; or

(2) By nurse delegation per WAC 246-840-910 through 246-840-970; unless

(3) Done by a family member or legally appointed resident representative.

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[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10455, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10460 Medication—Negotiated care plan. The adult family home must ensure that each resident's negotiated care plan addresses:

(1) The amount of medication assistance needed by each resident, including but not limited to:

(a) The reasons why a resident needs that amount of medication assistance; and

(b) When there is a need for the resident to have more than one type of medication assistance.

(2) How the resident will get their medications when the resident is away from the home or when a family member or resident representative is assisting with medications is not available.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10460, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10465 Medication—Altering—Requirements. (1) For the purposes of this section "altering a medication" means the alteration of prescribed or over the counter medications and includes, but is not limited to crushing tablets, cutting tablets in half; opening capsules and mixing powdered medications with food or liquids.

(2) The adult family home must consult with the practitioner or pharmacist before altering a medication and if the practitioner or pharmacist agrees with altering a medication, record the:

(a) Time;

(b) Date; and

(c) Name of the person who provided the consultation.

(3) The home must ensure the resident is aware that a medication is:

(a) Altered; and/or

(b) Put in the resident's food or drink.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10465, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10470 Medication—Timing—Special directions. (1) The adult family home must ensure medications are given:

(a) At the specific time(s) ordered by the practitioner; and

(b) As follows, when the practitioner does not order a medication to be given at a specific time:

(i) One time per day, approximately every twenty four hours;

(ii) Two times a day, approximately twelve hours apart;

(iii) Three times a day, approximately six hours apart;

and

(iv) Four times a day, approximately four hours apart.

(2) The home must ensure all directions given by the practitioner are followed when assisting or giving each resident medication. This includes but is not limited to:

(a) Before meals;

(b) After meals;

(c) With or without food; and

(d) At bed time.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10470, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10475 Medication—Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

(a) Name of the resident;

(b) Name of all prescribed and over-the-counter medications;

(c) Dosage of the medication;

(d) Frequency which the medications are taken; and

(e) Approximate time the resident must take each medication.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

(b) If the medication was refused and the reason for the refusal; and

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

(iii) A logged call requesting written verification of the change; and

(iv) A copy of written verification of the change from the practitioner received by the home by mail, facsimile, or other electronic means, or on new original labeled container from the pharmacy.

(4) Ensure that the changed or new medication is received from the pharmacy.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10475, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10480 Medication organizers. The adult family home must ensure:

(1) A licensed nurse, pharmacist, the resident or the resident's family member fills a resident's medication organizer;

(2) Prescribed and over-the-counter medications placed in a medication organizer come from the original container labeled for the resident by the pharmacist or pharmacy service;

(3) Each resident and anyone giving care to a resident can readily identify medications in the medication organizer;

(4) Medication organizer labels clearly show the following:

(a) The name of the resident;

(b) A list of all prescribed and over-the-counter medications;

(c) The dosage of each medication;

(d) The frequency which the medications are given.

(5) The person filling the medication organizer updates the labels on the medication organizer when the practitioner changes a medication.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10480, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(1) In locked storage;

(2) In the original container with legible and original labels; and

(3) Appropriately for each medication, such as if refrigeration is required for a medication and the medication is kept in refrigerator in locked storage.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10485, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10490 Medication disposal—Written policy—Required. The adult family home must have and implement a written policy addressing the disposition of resident prescribed medications that are unused, leftover, or remaining after the resident leaves the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10490, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10495 Specialty care—Designations. The department may designate an adult family home to provide specialty care in one or more of the following areas:

(1) Developmental disability;

(2) Mental illness; and

(3) Dementia.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10495, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10500 Granting specialty care designation—Requirements. The department will grant a specialty designation when:

(1) The provider, entity representative and resident manager has successfully completed training in one or more of the specialty care designated areas;

(2) The home provides the department with written documentation:

(a) Of successful completion of the required specialty care training or challenge test for each person in subsection (1) of this section; and

(b) For the specialty care training for all caregivers in the adult family home provided by a person knowledgeable in specialty care.

(3) The home ensures the specialty care need of each resident is met.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10500, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10505 Specialty care—Admitting and retaining residents. The provider or entity representative must not admit or keep a resident with specialty care needs, such as developmental disability, mental illness or dementia as defined in WAC 388-76-10000, if the provider, entity representative, resident manager and staff have not completed the specialty care training required by chapter 388-112 WAC.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10505, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10510 Resident rights—Basic rights. The adult family home must ensure that each resident:

(1) Receives appropriate services;

(2) Is treated with courtesy;

(3) Continues to enjoy basic civil and legal rights;

(4) Has the chance to exercise reasonable control over life decisions such as choice, participation, and privacy;

(5) Is provided the opportunity to engage in religious, political, civic, recreational, and other social activities of their choice;

(6) Is cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life including a safe, clean, comfortable, and home-like environment; and

(7) Is allowed to use his or her personal belongings to the extent possible.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10510, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10515 Resident rights—Exercise of rights. The adult family home must:

(1) Protect each resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the home;

(2) Protect and promote the rights of each resident and assist the resident to exercise his or her rights as a resident of the home, as a citizen or resident of the United States and the state of Washington.

(3) Be free of interference, coercion, discrimination, and reprisal from the home in exercising his or her rights; and

(4) Ensure the resident's right to choose a representative who may exercise the resident's rights to the extent provided by law.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10515, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10520 Resident rights—General notice. The adult family home must:

(1) Inform each resident both orally and in writing in a language the resident understands of resident rights and all rules and regulations governing resident conduct and responsibilities during the stay in the home;

(2) Ask the resident to sign and date they received the information; and

(3) Provide a statement indicating whether the provider or entity representative will accept Medicaid or other public funds as a source of payment for services.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10520, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10525 Resident rights—Description. The adult family home must give each resident a written description of resident's rights that includes a:

(1) Description of how the home will protect personal funds;

(2) Posting of names, addresses, and telephone numbers of the:

(a) State survey and certification agency;

(b) State licensing office;

(c) State ombudsmen program; and

(d) Protection and advocacy systems.

(3) Statement informing the resident that he or she may file a complaint with the appropriate state licensing agency concerning alleged abandonment, abuse, neglect, or financial exploitation.

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[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10525, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10530 Resident rights—Notice of services. The adult family home must provide each resident notice in writing and in a language the resident understands before admission, and at least once every twenty-four months after admission of the:

(1) Services, items, and activities customarily available in the home or arranged for by the home as permitted by the license;

(2) Charges for those services, items, and activities including charges for services, items, and activities not covered by the home's per diem rate or applicable public benefit programs; and

(3) Rules of the home's operations.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10530, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10535 Resident rights—Notice of change to services. (1) The adult family home must inform each resident:

(a) In writing; and

(b) In advance of changes in the availability of, or the charges for services, items, or activities, or of changes in the home's rules.

(2) The home must provide notice:

(a) Thirty days before the change, except in emergencies; or

(b) Fourteen days before the change, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities.

(3) The home is not required to give notice:

(a) If the home gives each resident written notice of the availability and charges of services, items and activities before admission, when there are changes and every twenty-four months; and

(b) If the resident is provided different or additional services, items or activities from the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10535, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10540 Resident rights—Disclosure of fees and notice requirements—Deposits. (1) Before admission, if the adult family home requires payment of an admissions fee, deposit, or a minimum stay fee, by or on behalf of a person seeking admission, the home must give the resident full disclosure in writing in a language the resident understands.

(2) The disclosure must include:

(a) A statement of the amount of any admissions fees, deposits, prepaid charges, or minimum stay fees;

(b) The home's advance notice or transfer requirements; and

(c) The amount of the deposits, admission fees, prepaid charges, or minimum stay fees that will be refunded to the resident if the resident leaves the home.

(3) The home must ensure that the receipt of the disclosures required under subsection (1) of this section is in writing and signed and dated by the resident and the home.

(4) If the home does not provide these disclosures, the home must not keep the deposits, admission fees, prepaid charges, or minimum stay fees.

(5) If a resident dies, is hospitalized or is transferred and does not return to the home, the adult family home:

(a) Must refund any deposit or charges already paid less the home's per diem rate for the days the resident actually resided, reserved or retained a bed in the home in spite of any minimum stay policy or discharge notice requirements; except that

(b) May keep an additional amount to cover its reasonable and actual expenses incurred as a result of a private-pay resident's move, not to exceed five days per diem charges; unless the resident has given advance notice in compliance with the admission agreement.

(6) All adult family homes covered under this section are required to refund any and all refunds due the resident within thirty days from the resident's date of discharge from the home.

(7) Nothing in this section applies to provisions in contracts negotiated between a home or and a certified health plan, health or disability insurer, health maintenance organization, managed care organization, or similar entities.

(8) If the home requires the implementation of an admission agreement by or on behalf of an individual seeking admission the home must ensure the terms of the agreement are consistent with the requirements of this section, chapters 70.128, 70.129 and 74.34 RCW, and other applicable state and federal laws.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10540, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10545 Resident rights—Admitting and keeping residents. The adult family home must:

(1) Only admit or keep individuals whose needs the home can safely serve in the home:

- (a) With appropriate available staff; and
- (b) Through the provision of reasonable accommodations required by state and federal law.

(2) Not admit an individual before obtaining a thorough assessment of the resident's needs and preferences, except in cases of a genuine emergency;

(3) Ensure that the admission of the individual does not negatively affect the ability of the home to meet the needs of or endangers the safety of other residents; and

(4) Comply with all applicable federal and state requirements regarding nondiscrimination.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10545, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10550 Resident rights—Adult family home staffing—Notification required. The adult family home must provide the following information to prospective residents and current residents:

(1) Information about the provider, entity representative and resident manager, if there is a resident manager:

- (a) Availability in the home, including a general statement about how often he or she is in the home;
- (b) Education and training relevant to resident caregiving;
- (c) Caregiving experience;

(d) His or her primary responsibilities, including whether he or she makes daily general care management decisions; and

(e) How to contact the provider, entity representative or resident manager when he or she is not in the home.

(2) Information about a licensed practical nurse or registered nurse, if there is one, who is in any way involved in the care of residents:

(a) Who the licensed practical nurse or registered nurse is employed by;

(b) The specific routine hours that the licensed practical nurse or registered nurse is on-site, if they are on-site routinely;

(c) His or her primary responsibilities, including whether he or she makes daily general care management decisions;

(d) The nonroutine times when the licensed practical nurse or registered nurse will be available, such as on-call; and

(e) A description of what the provider or entity representative will do to make available the services of a licensed nurse in an emergency or change in a resident's condition.

(3) A statement indicating whether the provider, entity provider, caregiver or staff is qualified or willing to become qualified to perform nurse delegation as allowed under state law.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10550, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10555 Resident rights—Financial affairs. Each resident has the right to manage his or her financial affairs, and the adult family home cannot require any resident to deposit their personal funds with the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10555, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10560 Resident rights—Adult family home management of resident financial affairs. If the adult family home agrees to manage a resident's personal funds, the home must do all of the following:

(1) Hold, safeguard, manage, and account for the personal funds of the resident deposited with the home;

(2) Have a written authorization from the resident;

(3) Deposit a resident's personal funds in excess of one hundred dollars in an interest-bearing account or accounts separate from any of the home's operating accounts, and that credits all interest earned on residents' funds to that account;

(4) If funds are pooled accounts, there must be a separate accounting for each resident's share; and

(5) Keep a resident's personal funds that do not exceed one hundred dollars in a noninterest-bearing account, interest-bearing account, or petty cash fund.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10560, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10565 Resident rights—Adult family home system for management of resident financial affairs. The adult family home that manages resident funds must:

(1) Develop and maintain a system that assures a full, complete, and separate accounting of each resident's personal funds given to the home on the resident's behalf;

(2) Ensure the:

(a) System prevents resident funds from being mixed with the home's funds or with the funds of any person other than another resident; and

(b) Individual financial record is available upon request to the resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10565, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10570 Resident rights—Financial affairs related to resident death. If a resident's personal funds are deposited with the adult family home, the home must give the resident's funds and a final accounting of the funds within forty-five days after the resident's death to the individual or probate jurisdiction administering the resident's estate; except for a resident who received long-term care services paid by the state, the home must send funds and accounting to the state of Washington, department of social and health services, office of financial recovery.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10570, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10575 Resident rights—Privacy. (1) The adult family home must ensure the right of each resident to personal privacy that includes:

- (a) The home;
- (b) Medical treatment;
- (c) Clinical or resident records;
- (d) Personal care; and
- (e) Visits and meetings of family and resident groups;

however

(2) The resident right to personal privacy does not require the home to provide a private room for each resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10575, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10580 Resident rights—Grievances. The adult family home must:

(1) Ensure each resident's right to voice grievances, including those about care and treatment given or not given that has been furnished as well as that which has not been furnished; and

(2) Make prompt efforts to resolve grievances the resident may have, including those about the behavior of other residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10580, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10585 Resident rights—Examination of inspection results. The adult family home must:

(1) Ensure each resident is given an opportunity to examine the most recent inspection report of the home and related plans of correction; and

(2) Post a notice in a visible location in the home indicating the inspection report is available for review.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10585, filed 10/16/07, effective 1/1/08.]

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WAC 388-76-10590 Resident rights—Contact with client advocates. The adult family home must ensure that each resident:

- (1) Receives information from client advocate agencies; and
- (2) Has opportunities to contact client advocate agencies.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10590, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10595 Resident rights—Advocacy access and visitation rights. The adult family home must not interfere with each resident's right to have access to and from:

- (1) Any representative of the state;
- (2) The resident's own physician;
- (3) The state long-term care ombudsman program as established under chapter 43.190 RCW;
- (4) The agency responsible for the protection and advocacy system for developmentally disabled individuals as established under Part C of the developmental disabilities assistance and bill of rights act;
- (5) The agency responsible for the protection and advocacy system for mentally ill individuals as established under the protection and advocacy for mentally ill individuals act;
- (6) Immediate family or other relatives of the resident and others who are visiting with the consent of the resident, subject to reasonable limits to protect the rights of others and to the resident's right to deny or withdraw consent at any time;
- (7) The agency responsible for the protection and advocacy system for individuals with disabilities as established under section 509 of the Rehabilitation Act of 1973, as amended, who are not served under the mandates of existing protection and advocacy systems created under federal law; and
- (8) The resident's representative or an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10595, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10600 Resident rights—Mail and telephone privacy. The adult family home must ensure each resident's right to privacy in communications, including the right to:

- (1) Send and receive unopened mail without delay;
- (2) Have writing paper, postage, and pens or pencils available that have been paid for by resident; and
- (3) Be able to use a telephone where calls can be made without being overheard.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10600, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10605 Resident rights—Personal property and storage space. The adult family home must ensure each resident's right to keep and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10605, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10610 Resident rights—Waiver of liability. The adult family home must not ask the resident for, or make the resident sign waivers of:

- (1) Potential liability for losses of personal property or injury; and
- (2) Residents' rights set forth in chapters 70.128, 70.129, 74.34 RCW, this chapter or in the applicable licensing laws.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10610, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10615 Resident rights—Transfer and discharge. (1) The adult family home must allow each resident to stay in the home, and not transfer or discharge the resident unless:

- (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the home;
 - (b) The safety or health of individuals in the home is or would otherwise be endangered;
 - (c) The resident has failed to make the required payment for his or her stay; or
 - (d) The home ceases to operate.
- (2) Before a home transfers or discharges a resident, the home must:

- (a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;
- (b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;
- (c) Record the reasons in the resident's record; and
- (d) Include in the notice the items described in subsection (5) of this section.

(3) Except as specified in (4) of this section, the home must give notice of the transfer or discharge at least thirty days before the resident is transferred or discharged.

(4) The home may make the notice as soon as practicable before transfer or discharge when:

- (a) The safety and health of the individuals in the home would be endangered;
 - (b) An immediate transfer or discharge is required by the resident's urgent medical needs; or
 - (c) A resident has not resided in the home for thirty days.
- (5) The home must include the following in the written notice specified in subsection (2) of this section:
- (a) The reason for transfer or discharge;
 - (b) The effective date of transfer or discharge;
 - (c) The location where the resident is transferred or discharged;
 - (d) The name, address, and telephone number of the state long-term care ombudsman;

(e) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals; and

(f) For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

(6) The home must give residents enough preparation and orientation to ensure a safe and orderly transfer or discharge from the home.

(7) If the home discharges a resident in violation of this section, the home must readmit the resident to the home as soon as a gender-appropriate bed becomes available.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10615, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10620 Resident rights—Quality of life—General. (1) The adult family home must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(2) Within reasonable home rules designed to protect the rights and quality of life of residents, the home must ensure the resident's right to:

- (a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and negotiated care plan;
- (b) Interact with members of the community both inside and outside the home;
- (c) Make choices about aspects of his or her life in the home that are significant to the resident;
- (d) Wear his or her own clothing and decide his or her own dress, hair style, or other personal effects according to individual preference;
- (e) Unless adjudged incompetent or otherwise found to be legally incapacitated to:
 - (i) Be informed in advance about recommended care and services and of any recommended changes in the care and services;
 - (ii) Participate in planning care and treatment or changes in care and treatment;
 - (iii) Direct his or her own service plan and changes in the service plan, or
 - (iv) Refuse any particular service so long as such refusal is documented in the record of the resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10620, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10625 Resident rights—Quality of life—Meetings. The adult family home must ensure:

- (1) A resident's right to:
 - (a) Organize and take part in resident groups in the home;
 - (b) Have family meet in the home with the families of other residents; and
 - (c) Have staff or visitors attend meetings at the group's invitation.
- (2) The home must provide a resident or family group, if one exists, with meeting space.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10625, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10630 Resident rights—Quality of life—Adult family home response to issues. When a resident or family group exists, the adult family home must listen to the views and act upon the grievances and recommendations of residents and families about proposed policy and

operational decisions affecting resident care and life in the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10630, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10635 Resident rights—Quality of life—Work. The adult family home must respect the resident's right to refuse to perform services for the home except as voluntarily agreed to by the resident and the home and documented in the resident's negotiated care plan.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10635, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10640 Resident rights—Quality of life—Resident participation. The adult family home must ensure each resident's right to join in social, religious, and community activities that do not interfere with the rights of other residents in the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10640, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10645 Resident rights—Quality of life—Reasonable accommodation. The adult family home must ensure each resident:

(1) Receives reasonable accommodation to meet the needs and preferences of the resident, except when the reasonable accommodation endangers the health or safety of the individual or other residents; and

(2) Has the ability to share a double room with his or her spouse when both spouses consent to the arrangement.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10645, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10650 Medical devices. Before the adult family home uses medical devices for any resident, the home must:

(1) Review the resident assessment to determine the resident's need for and use of a medical device;

(2) Ensure the resident negotiated care plan includes the resident use of a medical device or devices; and

(3) Provide the resident and family with enough information about the significance and level of the safety risk of use of the device to enable them to make an informed decision about whether or not the use the device.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10650, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10655 Physical restraints. The adult family home must ensure:

(1) Each resident's right to be free from physical restraints used for discipline or convenience;

(2) Less restrictive alternatives have been tried;

(3) That physical restraints used have been assessed as necessary to treat the resident's medical symptoms; and

(4) That if physical restraints are used to treat a resident's medical symptoms that the restraints are applied and immediately supervised on-site by a:

(a) Licensed registered nurse;

(b) Licensed practical nurse; or

(c) Licensed physician; and

(d) For the purposes of this subsection, immediate supervised means that the licensed person is in the home and quickly and easily available.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10655, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10660 Chemical restraints. (1) For the purposes of this section "chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident's medical symptoms.

(2) The adult family home must ensure that:

(a) Each resident is free from chemical restraints used for discipline or convenience;

(b) The resident assessment indicates that a chemical restraint is necessary to treat the resident's medical symptoms;

(c) In situations when a psychopharmacological drug is used for a resident, the home must ensure that the:

(i) Drug is prescribed by a physician or health care professional with prescriptive authority;

(ii) Resident's negotiated care plan includes strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;

(iii) Changes in medication only occur when the prescriber decides it is medically necessary; and

(iv) Resident has given informed consent for its use.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10660, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10665 Involuntary seclusion. The adult family home must ensure a resident's right to be free from involuntary seclusion or isolation of the resident against his or her will.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10665, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10670 Prevention of abuse. The adult family home must:

(1) Meet the requirements of chapter 74.34 RCW;

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

(3) Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion; and

(4) Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10670, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10675 Adult family home rules and policies related to abuse—Required. The adult family home must develop and implement written rules and policies that:

(1) Do not allow abandonment, abuse, neglect of any resident, exploitation or financial exploitation of any resident;

(2) Require staff to report possible abuse, and other related incidents, as required in chapter 74.34 RCW; and

(3) Do not interfere with the requirement that employees and other mandated reporters file reports directly with the department, and with law enforcement, if they suspect sexual or physical assault to have occurred.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10675, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10680 Staff behavior related to abuse.

The adult family home must ensure that staff do not abandon, abuse, neglect, seclude, exploit, or financially exploit any resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10680, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10685 Bedrooms. The adult family home must:

(1) Ensure each resident's bedroom is an outside room, which allows entrance of natural light;

(2) Ensure window and door screens:

(a) Do not hinder emergency escape; and

(b) Prevent entrance of flies and other insects.

(3) Ensure each resident's bedroom has direct access to hallways and corridors and unrestricted or free access to common use areas;

(4) Make separate bedrooms available for each sex;

(5) Make reasonable efforts to accommodate residents wanting to share the room;

(6) Provide each bedroom with a minimum usable floor space as required in WAC 388-76-10690.

(7) Ensure no more than two residents to a bedroom;

(8) Unless the resident chooses to provide their own furniture and bedding, the home must provide each resident a bed thirty-six inches or more wide with:

(a) A clean, comfortable mattress;

(b) A waterproof cover for use when needed or requested by the resident;

(c) Clean sheets and pillow cases;

(d) Adequate clean blankets to meet the needs of each resident; and

(e) Clean pillows.

(9) Not use the upper bunk of double-deck beds for a resident's bed;

(10) Provide a call bell or intercom system if the provider, entity representative, resident manager or caregiver bedroom is not within hearing distance of each resident bedroom and the system is required by the department;

(11) Ensure that members of the household, other than residents, do not share bedrooms with residents; and

(12) Ensure a resident does not share a bedroom with a person under eighteen years of age, unless the person is the resident's own child.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10685, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10690 Bedroom usable floor space—In adult family homes after the effective date of this chapter.

(1) For the purposes of this section "vestibule" means a small

room or hall between an outer door and the main part of the resident bedroom.

(2) The adult family home must ensure each resident bedroom has a minimum usable floor space as follows, excluding the floor space for toilet rooms, closets, lockers, wardrobes and vestibules:

(a) Single occupancy bedrooms with at least eighty square feet; and

(b) Double occupancy bedrooms with at least one-hundred twenty square feet.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10690, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10695 Building codes—Structural requirements. (1) For single family dwellings used as an adult family home after July 1, 2007, the home must ensure the building meets the requirements of WAC 51-51-0325 Section R325 if the building is:

(a) New; or

(b) An existing building converted for use as an adult family home.

(2) For buildings licensed as a home before July 1, 2007, the requirement of subsection (1) of this section does not apply if:

(a) The building sells or transfers to a new owner; and

(b) The new owner takes possession of the building before the issuance of the license.

(3) The home must ensure that every area used by residents:

(a) Has direct access to at least one exit which does not pass through other areas such as a room or garage subject to being locked or blocked from the opposite side; and

(b) Is not accessible only by or with the use of a:

(i) Ladder;

(ii) Folding stairs; or

(iii) Trap door.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10695, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10700 Building official—Inspection and approval. The adult family home must have the building inspected and approved for use as an adult family home by the local building official:

(1) Before licensing; and

(2) After any construction changes that:

(a) Affect resident's ability to exit the home; or

(b) Change, add or modify a resident's bedroom.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10700, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10705 Common use areas. (1) For the purposes of this section, common use areas:

(a) Are areas and rooms of the adult family home that residents use each day for tasks such as eating, visiting, and leisure activities; and

(b) Include but are not limited to dining and eating rooms, living and family rooms, and any entertainment and recreation areas.

(2) The adult family home must ensure common use areas are:

- (a) Homelike, with furnishings that each resident may use;
- (b) Large enough for all residents to use at the same time; and
- (c) Not used as bedrooms or sleeping areas.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10705, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10710 Construction and remodeling—Relocation of residents. Before moving all residents out of the adult family home for construction or remodeling, the home must:

- (1) Notify the residents of the move date and the resident's options consistent with chapter 70.129 RCW;
- (2) Notify the department at least thirty days before the anticipated move, including:
 - (a) The location to which the residents will be moved;
 - (b) The home's plans for providing and ensuring care and services during the relocation;
 - (c) The home's plans for returning residents to the building; and
 - (d) The projected time frame for completing the construction or remodeling.
- (3) Obtain the department's approval of the relocation plans before moving the residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10710, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10715 Doors—Ability to open. The adult family home must ensure:

- (1) Every bedroom and bathroom door opens from the inside and outside;
- (2) Every closet door opens from the inside and outside; and
- (3) All exit doors leading to the outside will open from the inside without a key or any special knowledge or effort by residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10715, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10720 Electronic monitoring equipment—Audio monitoring and video monitoring. (1) The adult family home must not use audio monitoring equipment:

- (a) In the home;
- (b) In combination with video monitoring equipment; and
- (c) Except as provided in section WAC 388-76-10725.
 - (2) The home may video monitor and video record activities in the home, without an audio component, only in the following areas:
 - (a) Entrances and exits if the cameras are:
 - (i) Focused only on the entrance or exit doorways; and
 - (ii) Not focused on areas where residents gather.
 - (b) Outdoor areas not commonly used by residents; and
 - (c) Designated smoking areas, subject to the following conditions when:
 - (i) Residents are assessed as needing supervision for smoking;
 - (ii) A staff person watches the video monitor at any time the area is used by such residents;

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10720, filed 10/16/07, effective 1/1/08.]

- (iii) The video camera is clearly visible;
- (iv) The video monitor is not viewable by general public; and
- (v) The home notifies all residents in writing of the video monitoring equipment.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10720, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10725 Electronic monitoring equipment—Resident requested use. (1) The adult family home must limit resident-requested audio or video monitoring equipment to the sleeping room of the resident who requested the monitoring.

- (2) If the resident requests audio or video monitoring, before any electronic monitoring occurs the home must ensure:
 - (a) Appropriate actions are taken to ensure electronic monitoring is consistent with and does not violate chapter 9.73 RCW;
 - (b) The resident has identified a threat to the resident's health, safety or personal property and has requested electronic monitoring;
 - (c) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and
 - (d) The resident and the home have agreed upon a specific duration for the electronic monitoring documented in writing.

(3) The home must reevaluate the need for the electronic monitoring with the resident at least quarterly and:

- (a) Must document the reevaluation in writing; and
- (b) Have each reevaluation signed and dated by the resident.
- (4) The home must immediately stop electronic monitoring if the:
 - (a) Resident no longer wants electronic monitoring;
 - (b) Roommate objects or withdraws the consent to the electronic monitoring, or
 - (c) Resident becomes unable to give consent.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10725, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10730 Grab bars and hand rails. (1) The adult family home must install grab bars or hand rails to meet the needs of each resident.

- (2) At a minimum, grab bars must be installed and securely fastened in:
 - (a) Bathing facilities such as tubs and showers; and
 - (b) Next to toilets, if needed by any resident.
 - (3) If needed by any resident, hand rails must be installed and conveniently located on:
 - (a) A step or steps; and
 - (b) Ramps.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10730, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10735 Kitchen facilities. (1) The adult family home must ensure the kitchen facilities include adequate space for:

- (a) Food handling;

- (b) Preparation; and
- (c) Food storage.

(2) The home must keep the kitchen and equipment in a clean and sanitary manner.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10735, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10740 Lighting. The adult family home must provide:

(1) Adequate light fixtures for each task a resident or staff does; and

(2) Emergency lighting, such as working flashlights for staff and residents that are readily accessible.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10740, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10745 Local codes and ordinances. The adult family home must:

(1) Meet all applicable local licensing, zoning, building and housing codes as they pertain to a single family dwelling;

(2) Meet state and local fire safety regulations as they pertain to a single family dwelling; and

(3) Check with local authorities to ensure the home meets all local codes and ordinances.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10745, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, home-like environment that is free of hazards;

(2) Provide clean, functioning, safe, adequate household items and furnishings to meet the needs of each resident;

(3) Provide safe and functioning systems for:

- (a) Heating;
- (b) Cooling, which may include air circulating fans;
- (c) Hot and cold water;
- (d) Electricity;
- (e) Plumbing;
- (f) Garbage disposal;
- (g) Sewage;
- (h) Cooking;
- (i) Laundry;
- (j) Artificial and natural light;
- (k) Ventilation; and
- (l) Any other feature of the home.

(4) Ensure water temperature does not exceed one hundred twenty degrees Fahrenheit at all fixtures used by or accessible to residents, such as:

- (a) Tubs;
- (b) Showers; and
- (c) Sinks.

(5) Provide storage for toxic substances, poisons, and other hazardous materials that is only accessible to residents under direct supervision, unless the resident is assessed for and the negotiated care plan indicates it is safe for the resident to use the materials unsupervised;

(6) Provide rapid access for all staff to any bedroom, toilet room, shower room, closet, other room occupied by each resident;

(7) Keep all firearms locked and accessible only to authorized persons; and

(8) Keep the home free from:

- (a) Rodents;
- (b) Flies;
- (c) Cockroaches, and
- (d) Other vermin.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10750, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10755 Sewage and liquid wastes. The adult family home must ensure sewage and liquid wastes are discharged into:

- (1) A public sewer system; or
- (2) An independent sewage system approved by the local health authority.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10755, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10760 Site. The adult family home must ensure the home:

- (1) Is on a well drained site free from:
 - (a) Hazardous conditions;
 - (b) Excessive noise;
 - (c) Dust; and
 - (d) Smoke or odors.
- (2) Has a road accessible at all times to emergency vehicles.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10760, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10765 Storage. The adult family home must:

(1) Supply each resident with adequate and reasonable storage space for:

- (a) Clothing;
- (b) Personal possessions; and
- (c) Upon request, lockable container or storage space for small items, unless the:
 - (i) Resident has a private room; and
 - (ii) The resident room can be locked by the resident.

(2) Provide locked storage for all prescribed and over-the-counter medications as per WAC 388-76-10485.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10765, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10770 Telephones. The adult family home must provide:

- (1) At least one working nonpay telephone in the home;
- (2) Residents reasonable access to the telephone; and
- (3) Privacy for the resident when making or receiving calls.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10770, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10775 Temperature and ventilation. The adult family home must:

- (1) Keep room temperature at:
 - (a) Sixty-eight degrees Fahrenheit or more during waking hours;
 - (b) Sixty degrees Fahrenheit or more during sleeping hours; and
 - (c) Not more than seventy-eight degrees Fahrenheit day or night.
- (2) Provide ventilation in the home to ensure the health and comfort of each resident is met.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10775, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10780 Toilets and bathing facilities. (1) The adult family home must ensure the home has toilets and bathing facilities that provide each resident with privacy and include:

- (a) One indoor flush toilet for each five persons including residents and household members in the home; and
 - (b) Sinks with hot and cold running water.
- (2) Homes licensed after July 1, 2007, must ensure each resident has access to a toilet, shower or tub without going through another resident's room.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10780, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10785 Water hazards—Enclosures and safety devices. (1) For the purposes of this section "water hazard" means any body of water over twenty-four inches in depth that can be accessed by a resident, and includes but is not limited to:

- (a) In-ground, above-ground, and on-ground pools;
 - (b) Hot tubs, spas; or
 - (c) Fixed-in-place wading pools.
- (2) The adult family home must:
- (a) Protect each resident from risks of bodies of water of any depth and water hazards;
 - (b) Ensure that water hazard protection complies with this section and the requirements of the:
 - (i) International Residential Code (IRC); and
 - (ii) Washington state amendments to the International Residential Code (IRC).
 - (c) Provide each area which allows direct access to a water hazard with:
 - (i) A minimum of forty-eight inch high fences and gates to enclose or protect each resident from the water hazard;
 - (ii) Alarms that produce an audible warning when opened on all doors and screens, if present and gates.
- (3) After July 1, 2007, existing adult family homes are required to meet the requirements of this section when installing or making construction changes to the following:
- (a) In-ground, above-ground and on-ground pools;
 - (b) Hot tubs, spas;
 - (c) Decorative water features; or
 - (d) Fixed-in-place wading pools.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10785, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10790 Water supply. The adult family home must:

- (1) Obtain local health authority approval to use a private water supply;
- (2) Provide a clean and healthy drinking water supply for the home; and
- (3) Label any nonpotable water to avoid use as a drinking water source.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10790, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10795 Windows. (1) The adult family home must ensure the sill height of the bedroom window is not more than forty-four inches above the floor.

(2) For homes licensed after July 1, 2007, the department will not approve alternatives to the sill height requirement such as step(s), raised platform(s) or other devices placed by or under the window openings.

(3) The bedroom window must have the following:

- (a) A minimum opening area of 5.7 square feet except a grade level floor window openings may have a minimum clear opening of 5.0 square feet;
 - (b) A minimum opening height of twenty-four inches; and
 - (c) A minimum opening width of twenty inches.
- (4) The home must ensure the bedroom window can be opened from inside the room without keys or tools.

(5) When resident bedroom windows are fitted with storm windows, the home must equip the storm windows with release mechanisms that:

- (a) Easily open from the inside; and
- (b) Do not require a key or special knowledge or effort to open.

(6) The home must ensure that each basement and each resident bedroom window, that meets the requirements of subsection (1), (2) and (3) of this section, are kept free from obstructions that might block or interfere with access for emergency escape or rescue.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10795, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10800 Adult family home located outside of public fire protection. If the adult family home is located in an area without public fire protection, the home must have written verification of adequate fire protection from the fire authority.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10800, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10805 Automatic smoke detectors. The adult family home must ensure approved automatic smoke detectors are:

- (1) Installed, at a minimum, in the following locations:
 - (a) Every bedroom used by a resident;
 - (b) In proximity to the area where the resident or adult family home staff sleeps; and
 - (c) On every level of a multilevel home.
- (2) Installed in a manner so that the fire warning is heard in all parts of the home upon activation of a single detector; and
- (3) Kept in working condition at all times.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10805, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10810 Fire extinguishers. (1) The adult family home must have an approved five pound 2A:10B-C rated fire extinguisher on each floor of the home.

(2) The home must ensure the fire extinguishers are:

(a) Installed according to manufacturer recommendations;

(b) Inspected and serviced annually;

(c) In proper working order; and

(d) Readily available for use at all times.

(2) If required by the local fire authority, the home must provide different fire extinguishers in place of the fire extinguishers required in subsection (1) of this section.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10810, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10815 Notice required—Compliance with building code and fire protection. Before a resident is admitted, the adult family home must disclose in writing in a language understood by the prospective resident the following:

(1) Whether or not resident bedrooms comply with the current building code including evacuation standards; and

(2) If the home is located outside a public fire district, the source and plan for on-site fire protection.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10815, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10820 Resident evacuation capabilities and location of resident bedrooms. (1) The adult family home must ensure each resident who has an evacuation capability of Level 2 or Level 3, as defined in WAC 388-76-10870, has a bedroom located on grade level and exiting the building does not require the use of:

(a) Stairs;

(b) Elevator; or

(c) Lift.

(2) The home must install alternative emergency evacuation protection equipment when serving hearing or visually impaired residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10820, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10825 Space heaters and stoves. The adult family home must ensure:

(1) The following space heaters are not used in a home except during a power outage and the portable heater is only safe source of heat:

(a) Oil;

(b) Gas;

(c) Kerosene; and

(d) Electric.

(2) Stoves and heaters do not block residents, staff or household members from escaping.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10825, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10830 Emergency and disaster plan—Required. The adult family home must have written emergency and disaster plan and procedures to meet the needs of each resident during emergencies and disasters.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10830, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10835 Elements of an emergency and disaster plan. The adult family home must ensure the emergency and disaster plan includes:

(1) Plans for responding to natural and man-made emergencies and disasters that may reasonably occur at the home;

(2) Actions to be taken by staff and residents when an emergency or disaster strikes; and

(3) The fire drill plan for evacuation of the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10835, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10840 Emergency food supply. The adult family home must have an on-site emergency food supply that can be stored with other food in the home and that:

(1) Will last for a minimum of seventy-two hours; and

(2) Meets the dietary needs of each resident, including any specific dietary restrictions any resident may have.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10840, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10845 Emergency drinking water supply. The adult family home must have an on-site emergency supply of drinking water that:

(1) Will last for a minimum of seventy-two hours for each resident;

(2) Is at least three gallons for each resident;

(3) Is stored in food grade or glass containers;

(4) Is chemically treated or replaced every six months; and

(5) Is stored appropriately.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10845, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10850 Emergency medical supplies. The adult family home must have emergency medical supplies that include:

(1) First-aid supplies; and

(2) A first-aid manual.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10850, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10855 Emergency and disaster plan training—Required. The adult family home must ensure all staff are trained on the emergency and disaster plan and procedures when they begin work in the home and all staff and residents review the emergency and disaster plan and procedures at least annually.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10855, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10860 Fire drill plan and procedures for emergency evacuation—Required. The adult family home must:

(1) Have a fire drill plan and procedures for the emergency evacuation of all residents from the adult family home; and

(2) Not admit and keep residents the provider or entity representative cannot safely evacuate from the adult family home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10860, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10865 Emergency evacuation from adult family home. The adult family home must be able to evacuate all people living in the home:

- (1) From the home to a safe location outside the home; and
- (2) In five minutes or less.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10865, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10870 Resident evacuation capability levels—Identification required. The adult family home must ensure that each resident preliminary service plan and negotiated care plan contains the resident's ability to evacuate the home according to the following levels:

- (1) **Level 1** - resident is capable of walking or traversing a normal pathway to safety without the physical assistance of another individual;
- (2) **Level 2** - resident is physically and mentally capable of traversing a normal pathway to safety with mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual; and
- (3) **Level 3** - resident is unable to walk or transverse a normal pathway to safety without the physical assistance of another individual.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10870, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10880 Emergency evacuation adult family home floor plan. The adult family home must ensure each resident with an evacuation capability of Level 2 or Level 3 has a bedroom on a ground-level floor which:

- (1) Has at least two means of exiting the bedroom; and
- (2) Exiting from the bedroom does not require the use of:
 - (a) Stairs;
 - (b) Elevators; or
 - (c) A platform lift.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10880, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10885 Elements of emergency evacuation floor plan. The adult family home must ensure the emergency evacuation floor plan has:

- (1) An accurate floor plan of the home, including rooms, hallways, exits (such as doorways and windows) to the outside of the home;
- (2) Emergency evacuation routes showing the paths to take to exit the home; and
- (3) The location for the residents to meet outside the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10885, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10890 Posting the emergency evacuation floor plan—Required. The adult family home must dis-

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play an emergency evacuation floor plan on each floor of the home in:

- (1) A visible location in the home; and
- (2) Common areas normally used by residents, staff and visitors.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10890, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10895 Emergency evacuation drills—Frequency and participation. The adult family home must ensure:

- (1) Emergency evacuation drills occur at least every two months; and
- (2) All residents take part in at least one emergency evacuation drill each calendar year involving full evacuation from the home to a safe location.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10895, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10900 Documentation of emergency evacuation drills—Required. The adult family home must document in writing the emergency evacuation drills which must include:

- (1) Names of each resident and staff involved in the drill;
- (2) Name of the person conducting the drill;
- (3) Date and time of the drill; and
- (4) The length of time it took to evacuate all residents.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10900, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10905 Emergency evacuation—Notification of department required. The adult family home must immediately call the department's complaint toll free complaint telephone number of:

- (1) Any fire; or
- (2) Emergency evacuation from the home.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10905, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10910 Inspections—Complaint investigations—Monitoring visits—General. The department must conduct unannounced inspections, complaint investigations and monitoring visits to determine if the adult family home is in compliance with chapters 70.128, 70.129 and 74.34 RCW, this chapter and other applicable laws and regulations.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10910, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10915 Department staff access—Willful interference prohibited. The adult family home must ensure:

- (1) Department staff have access to:
 - (a) The home, residents, including former residents;
 - (b) Resident records, includes former residents records; and
 - (c) Facility staff and relevant staff records.
- (2) The home and staff do not willfully interfere or fail to cooperate with department staff in the performance of official duties.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10915, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10920 Inspection and investigation reports—Provided by department. The department will mail or hand deliver the department's report to the provider or entity representative:

- (1) Within ten working days of completion of the inspection process; or
- (2) Within ten calendar days of completion of the inspection if the home does not have a deficiency.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10920, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10925 Disclosure of inspection and complaint investigation reports. Upon request, the department must provide the public with copies, subject to applicable public disclosure and confidentiality requirements, of:

- (1) Inspection and complaint investigation reports as soon as they are completed;
- (2) The home's plan of correction, if a copy is available at the time of the request; and
- (3) Any final written decision by the department to take an enforcement action.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10925, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10930 Plan of correction (POC)—Required. The plan of correction included on the inspection report must:

- (1) Be completed by the adult family home and returned to the department within ten days of receiving the inspection report;
- (2) Include an attestation statement stating:
 - (a) What the home did or will do to correct each deficiency;
 - (b) That all deficiencies are or will be corrected;
 - (c) The home will stay in compliance with the licensing requirements;
 - (d) Dates, acceptable to the department, by which each cited deficiency has been or will be corrected; and
 - (e) A signature by the home, certifying that the home has or will correct each deficiency.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10930, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10935 Washington protection and advocacy—Long-term care ombudsman—Official duties—Penalty for interference. The adult family home must not willfully interfere with a representative of the following in the performance of official duties:

- (1) Washington protection and advocacy system as defined under RCW 71A.10.080; or
- (2) Long-term care ombudsman as defined under chapter 43.190 RCW, the state regulations for the long-term care ombudsman and under federal law.
- (3) The department must impose a civil penalty as per WAC 388-76-10975 for any such willful interference with a representative of the long-term care ombudsman program.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10935, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10940 Remedies—Generally. The department may take one or more of the following actions in any case which the department finds that an adult family home failed or refused to comply with the applicable requirements of chapters 70.128, 70.129, or 74.34 RCW or this chapter:

- (1) Denial of an application for a license;
- (2) Impose reasonable conditions on a license;
- (3) Impose civil penalties;
- (4) Order stop placement; and/or
- (5) Suspension or revocation of a license.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10940, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10945 Remedies—Serious risk—Recurring violations—Uncorrected violations. The department must impose a remedy or remedies listed in WAC 388-76-10940 when violations of chapter 70.128, 70.129 and 74.34 RCW and this chapter pose a serious risk to any resident, are recurring or are uncorrected.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10945, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10950 Remedies—History and actions by individuals. The department will consider the history and actions of the following individual or combination of individuals when imposing remedies:

- (1) Applicant;
- (2) Provider;
- (3) Entity representative;
- (4) Person affiliated with the applicant;
- (5) Resident manager;
- (6) A partner, officer, director or managerial employee of the entity;
- (7) Spouse of the provider or entity representative;
- (8) An owner:
 - (a) Of fifty-one percent or more of the entity;
 - (b) Who exercises control over the daily operations of the home.
- (9) A caregiver; or
- (10) Any person who:
 - (a) Has unsupervised access to residents in the home; and
 - (b) Lives in the home but who is not a resident.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10950, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10955 Remedies—Department must impose remedies. The department must impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950 has:

- (1) A history of prior violations of chapter 70.128 RCW or any law relating to residential care facilities within the past five years that resulted in revocation, suspension, or non-renewal of a license or contract with the department;
- (2) When providing care or services to children or vulnerable adults:
 - (a) Been found to be in significant noncompliance with federal or state regulations; or
 - (b) Had a license for the care of children or vulnerable adults suspended or revoked.

(3) Been enjoined from operating a facility for the care and services of children or adults;

(4) A stipulated finding of fact, conclusion of law, an agreed order, finding of fact, conclusion of law, final order issued by a disciplining authority or final decision by any federal or state agency or department, a court of law, or entered into a state registry or department or agency list with a finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW;

(5) Had a revocation or suspension of a license for the care of children or adults;

(6) Had a revocation, cancellation, suspension or nonrenewal of:

(a) A Medicaid or Medicare provider agreement by the contracting agency; or

(b) Any agreement with a public agency for the care and treatment of children or vulnerable adults, when the action was taken by the public agency.

(7) Been convicted of any crime listed in RCW 43.43.830 or 43.43.842;

(8) Been found by a court:

(a) In a protection proceeding under chapter 74.34 RCW to have abandoned, neglected, abused, or financially exploited a vulnerable adult; or

(b) In a domestic relations proceeding under Title 26 RCW to have sexually or physically abused, neglected or exploited any minor.

(9) Been found in any final decision issued by a disciplinary board to have:

(a) Sexually or physically abused, neglected or exploited any minor or a person with a developmental disability; or

(b) Abandoned, abused, neglected or financially exploited any vulnerable adult.

(10) Found in any dependency action under RCW 13.34.030 (5)(b) to have sexually or physically abused, neglected or exploited any minor; or

(11) Failed to pay the annual licensing fee.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10955, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10960 Remedies—Department may impose remedies. The department may impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950 has:

(1) Been convicted of a crime:

(a) As defined under RCW 43.43.830 or 43.43.842;

(b) Relating to financial exploitation as defined under RCW 43.43.830 or 43.43.842;

(c) Or a felony against a person if the conviction reasonably relates to the competency of the person to own or operate an adult family home;

(d) Involving a firearm used in the commission of a felony or in any act of violence against a person;

(e) Or engaged in illegally selling or distributing drugs, illegal use of drugs or excessive use of alcohol within the past five years without the evidence of rehabilitation.

(2) Been found by a court in a protection proceeding under chapter 74.34.RCW to have abandoned, abused, neglected, or financially exploited a vulnerable adult;

(3) Been found in a final decision issued by a disciplinary board to have sexually or physically abused, neglected or

exploited any minor person or a person with a developmental disability or to have abused or financially exploited any vulnerable adult;

(4) Been found in any dependency action under RCW 13.34.030(5) to have sexually abused, neglected or exploited any minor or to have physically abused any minor;

(5) Been found in a court domestic relations proceeding under Title 26 RCW to have:

(a) Sexually abused, neglected or exploited any minor or to have physically abused any minor;

(b) Committed an act of domestic violence toward a family or household member.

(6) Had a sanction, corrective, or remedial action taken by federal, state, county, or municipal officials or safety officials related to the care or treatment of children or vulnerable adults;

(7) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(8) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached to the application or in any matter under investigation by the department;

(9) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(10) Willfully prevented or interfered with or failed to cooperate with any inspection, investigation or monitoring visit made by the department;

(11) Failed or refused to comply with:

(a) A condition imposed on a license or a stop placement order;

(b) The applicable requirements of chapters 70.128, 70.129, 74.34 RCW or this chapter.

(12) Misappropriated property of a resident;

(13) Been denied a license or license renewal to operate a facility that was licensed to care for children or vulnerable adults;

(14) Exceeded licensed capacity in the operation of an adult family home;

(15) Operated a facility for the care of children or adults without a license or revoked license;

(16) Relinquished or returned a license in connection with the operation of any facility for the care of children or adults, or did not seek license renewal following written notification of the licensing agency's intention of denial, suspension, cancellation or revocation of a license;

(17) Had resident trust funds or assets of an entity providing care to children or vulnerable adults seized by the Internal Revenue Service or a state entity for failure to pay income or payroll taxes;

(18) Failed to meet financial obligations as the obligations fell due in the normal course of business, thereby impeding the ability to provide care and services to residents;

(19) Refused to permit authorized department representatives to interview residents or to have access to resident records or home;

(20) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties; or

(21) Found to be in noncompliance with the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter or other applicable laws and regulations.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10960, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10965 Remedies—Specific—Denial of application for license. The department decision to deny an application for a license is specified in:

- (1) WAC 388-76-10115;
- (2) WAC 388-76-10120;
- (3) WAC 388-76-10125; and
- (4) WAC 388-76-10940.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10965, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10970 Remedies—Specific—Condition(s) on license. (1) The department may impose reasonable conditions on the license.

(2) Conditions the department may impose on a license include, but are not limited to the following:

- (a) Correction within a specified time;
- (b) Training related to the deficiencies;
- (c) Limits on the type of residents the provider or entity representative may admit or serve;
- (d) Discharge of any resident when the department finds discharge is needed to meet that resident's needs or for the protection of other residents;
- (e) Change in license capacity;
- (f) Removal of the adult family home's designation as a specialized home;
- (g) Prohibition of access to residents by a specified person; and
- (h) Demonstration of ability to meet financial obligations necessary to continue operation.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10970, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10975 Remedies—Specific—Civil penalties. (1) The department may impose civil penalties of not more than one hundred dollars per day per violation except that:

(a) Fines up to one thousand dollars can be issued for willful interference with a representative of the long-term care ombudsman per RCW 70.129.150; and

(b) Fines up to three thousand dollars can be issued for retaliation against a resident, employee, or any other person making a complaint, providing information to, or cooperating with, the ombudsman, the department, the attorney's general office, or a law enforcement agency per RCW 74.34.060(7).

(2) When the provider or entity provider fails to pay a fine when due under this chapter, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from any contract payment due to the provider or entity provider from the department.

(3) Civil monetary penalties are due twenty-eight days after the provider, entity representative or the owner or operator of an unlicensed adult family home is served with notice of the penalty unless the provider or entity representative requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If the hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Interest accrues beginning thirty days after the department serves the provider or entity provider

with notice of the penalty at a rate of one percent per month as per RCW 43.20B.695.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10975, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10980 Remedies—Specific—Stop placement—Admissions prohibited. (1) The department may order stop placement and prohibit the admission of residents if the home does not meet the requirements of chapters 70.128, 70.129, 74.32 RCW or this chapter.

(2) Once imposed, the adult family home must not admit any person until the stop placement order is terminated.

(3) If the home requests, the department may approve readmission of a resident to the home from a hospital or nursing home during the stop placement.

(4) The department must end the stop placement when the department finds the:

- (a) Deficiencies necessitating the stop placement have been corrected; and
- (b) Home can show it has the capacity to maintain adequate care and service.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10980, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10985 Remedies—May extend to multiple homes. (1) When the department finds that a licensed provider or entity representative also operates an unlicensed adult family home, the department may impose a remedy or remedies listed in WAC 388-76-10940 on the provider or entity representative and the provider's or entity representative's licensed adult family home or homes.

(2) When the department finds that violations existing in an adult family home are of such nature as to present a serious risk or harm to residents of other homes operated by the same provider or entity representative, and after the department investigates other homes licensed by the same provider or entity representative the department may impose remedies on those other homes.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10985, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10990 Informal dispute resolution (IDR). (1) When a provider or entity representative disagrees with the department's finding of a violation under this chapter, the provider or entity representative shall have the right to have the violation reviewed by the department under the department's dispute resolution process.

(2) The purpose of the review is to give the provider or entity representative an opportunity to present information which might warrant modification or deletion of a finding of a violation.

(3) The provider or entity representative may submit a written statement for review.

(4) In addition to a written statement, the provider or entity representative may ask to present the information in person to a department designee.

(5) Requests for review must be made in writing to the department at the address provided in the department's certified letter within ten working days of receipt of the written finding of a violation.

(6) When requested by the provider or entity representative, the department must expedite the dispute resolution process to review violations upon which a department order imposing license suspension, revocation, stop placement, or condition on a license is based.

(7) Orders of the department imposing license suspension, stop placement, or conditions on a license are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10990, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10995 Notice, hearing rights, and effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 70.128 RCW, except that orders of the department imposing license suspension, stop placement, or conditions on license are effective immediately upon notice and must continue pending a final administrative decision.

(2) A provider contesting any decision by the department to impose a remedy must within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the board of appeals at the mailing address contained in WAC 388-02-0030; and

(b) Include in or with the application:

(i) The reasons for contesting the department decision; and

(ii) A copy of the contested department decision.

(3) Administrative proceedings are governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-02 WAC. If any provision in this section conflicts with chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10995, filed 10/16/07, effective 1/1/08.]

Chapter 388-101 WAC

CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS

WAC

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| 388-101-4300 | Disclosure of investigative and finding information. | | |
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| 388-101-4320 | Appeal of the administrative law judge's preliminary order on a finding. | | |
| 388-101-4330 | Finalizing a preliminary finding. | 388-101-1141 | Finalizing an initial finding. [Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1141, filed 8/29/06, effective 10/1/06.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-4340 | Reporting final findings. | | |

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

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| 388-101-1010 | What is the purpose of this chapter? [05-05-077, recodified as § 388-101-1010, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-010, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-010, filed 5/1/96, effective 6/1/96. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-010, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-010, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1146 | Reporting final findings. [Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1146, filed 8/29/06, effective 10/1/06.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1020 | What definitions apply to this chapter? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1020, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1020, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-020, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-020, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-020, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-020, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 86-08-003 (Order 2349), § 275-26-020, filed 3/20/86; 83-05-017 (Order 1945), § 275-26-020, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1180 | What are residential services? [05-05-077, recodified as § 388-101-1180, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-030, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-030, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-030, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-022, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-26-022, filed 2/5/90, effective 3/1/90. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-022, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1101 | Abuse and neglect reporting requirements. [Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1101, filed 8/29/06, effective 10/1/06.] Repealed by 08-02-022, | 388-101-1190 | Who certifies residential services? [05-05-077, recodified as § 388-101-1190, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-040, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-040, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-050, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-050, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |

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| 388-101-1200 | Where are residential services provided? [05-05-077, recodified as § 388-101-1200, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-050, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-050, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-060, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-060, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-090, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-090, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-076, filed 5/1/96, effective 6/1/96.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | |
| 388-101-1205 | Where are crisis diversion services provided? [05-07-138, recodified as § 388-101-1205, filed 3/22/05, effective 3/22/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-056, filed 1/29/04, effective 2/29/04.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1400 | When must a service provider document a client's refusal to participate in services? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1400, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1400, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-100, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-100, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-087, filed 8/9/91, effective 9/9/91.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1210 | Who may receive residential services? [05-05-077, recodified as § 388-101-1210, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-060, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-060, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-070, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-070, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1410 | May a service provider offer services to nonclients in the same household as clients? [05-05-077, recodified as § 388-101-1410, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-110, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-110, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-097, filed 2/9/83.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1220 | What physical and safety requirements exist for residential services? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1220, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1220, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-070, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-070, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-072, filed 8/9/91, effective 9/9/91.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1420 | Who pays for a client's residential services? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1420, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1420, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-120, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-120, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-107, filed 8/9/91, effective 9/9/91.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1230 | How must service providers assist clients in regulating water temperature? [05-05-077, recodified as § 388-101-1230, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-076, filed 1/29/04, effective 2/29/04.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1430 | When may a service provider receive initial set-up funds from DSHS? [05-05-077, recodified as § 388-101-1430, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-130, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-115, filed 8/9/91, effective 9/9/91.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1240 | What are supported living services? [05-05-077, recodified as § 388-101-1240, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-080, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-080, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-074, filed 5/1/96, effective 6/1/96.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1440 | What are the different types of certification? [05-05-077, recodified as § 388-101-1440, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-140, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-140, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1250 | What are crisis diversion services? [05-05-077, recodified as § 388-101-1250, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-086, filed 1/29/04, effective 2/29/04.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1460 | When may RCS grant initial certification to an agency? [05-05-077, recodified as § 388-101-1460, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-150, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-150, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1260 | What are group homes? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1260, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1260, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-090, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-090, filed | 388-101-1470 | How does an agency apply for initial certification? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1470, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1470, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-160, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-160, filed 10/26/01, |

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| | effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | | Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1480 | What happens after an agency receives initial certification? [05-05-077, recodified as § 388-101-1480, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-170, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1610 | What type of administrative documents are service providers required to have? [05-05-077, recodified as § 388-101-1610, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-260, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-260, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-260, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1490 | May initial certification be extended for a service provider? [05-05-077, recodified as § 388-101-1490, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-180, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-180, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1620 | What are the requirements for personnel policies? [05-05-077, recodified as § 388-101-1620, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-270, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1500 | How does a service provider receive regular certification? [05-05-077, recodified as § 388-101-1500, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-190, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-190, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1630 | What nondiscrimination requirements must agencies and service providers meet? [05-05-077, recodified as § 388-101-1630, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-280, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1510 | How often are reviews and evaluations done for service providers? [05-05-077, recodified as § 388-101-1510, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-200, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-200, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1640 | What staffing requirements must service providers meet? [05-05-077, recodified as § 388-101-1640, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-290, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-290, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-290, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1520 | What occurs during review and evaluation? [05-05-077, recodified as § 388-101-1520, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-210, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-210, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1650 | May clients instruct and support other clients? [05-05-077, recodified as § 388-101-1650, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-300, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-300, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1530 | May service providers disagree with evaluation findings? [05-05-077, recodified as § 388-101-1530, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-220, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-220, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1660 | Who needs background checks? [05-05-077, recodified as § 388-101-1660, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-310, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-310, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-310, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1540 | May a service provider receive provisional certification? [05-05-077, recodified as § 388-101-1540, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-230, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-230, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-230, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1670 | What are the minimum requirements for staff employed by service providers? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1670, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1670, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-320, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-320, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1550 | When may RCS decertify a service provider? [05-05-077, recodified as § 388-101-1550, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-240, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-240, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-1680 | What staff training is required? [05-05-077, recodified as § 388-101-16800, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-330, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-330, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-330, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1600 | What are administrators of service providers required to do? [05-05-077, recodified as § 388-101-1600, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-250, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-250, filed 10/26/01, effective 1/1/02.] | 388-101-1690 | How often must performance reviews be conducted for staff of service providers? [05-05-077, recodified as § |

- 388-101-1690, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-340, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-340, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1700 When must service providers have staff-coverage schedules approved by DDD? [05-05-077, recodified as § 388-101-1700, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-350, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-350, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1710 What happens when a service provider's ownership changes? [05-05-077, recodified as § 388-101-1710, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-360, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-360, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1720 When may a client's service provider change? [05-05-077, recodified as § 388-101-1720, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-370, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1730 Are clients' records considered confidential? [05-05-077, recodified as § 388-101-1730, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-380, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1740 How long does a service provider need to keep client records? [05-05-077, recodified as § 388-101-1740, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-390, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1750 What information do service providers need to keep in client records? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1750, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1750, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-400, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-400, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-400, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1760 What information do crisis diversion service providers need to keep in client records? [05-05-077, recodified as § 388-101-1760, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-405, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-405, filed 1/29/04, effective 2/29/04.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1770 Do service providers need to keep client's property records? [05-05-077, recodified as § 388-101-1770, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-410, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-410, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1780 Are there requirements for record entries? [05-05-077, recodified as § 388-101-1780, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-420, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1790 Who must service providers notify in emergencies? [05-05-077, recodified as § 388-101-1790, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-430, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-430, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1800 What are client services? [05-05-077, recodified as § 388-101-1800, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-450, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1810 What health and safety support may a service provider offer to a client? [05-05-077, recodified as § 388-101-1810, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-460, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1820 What support may a service provider offer to a client to increase personal power and choices? [05-05-077, recodified as § 388-101-1820, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-470, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1830 What support may a service provider offer to increase a client's competence and self-reliance? [05-05-077, recodified as § 388-101-1830, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-480, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1840 How may service providers assist clients in gaining positive recognition? [05-05-077, recodified as § 388-101-1840, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-490, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1850 What support may a service provider offer to increase the positive relationships in the client's life? [05-05-077, recodified as § 388-101-1850, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-500, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1860 How may a service provider assist clients with becoming integrated into their community? [05-05-077, recodified as § 388-101-1860, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-510, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1870 What is an individual service plan/plan of care (ISP/POC) for clients? [05-05-077, recodified as § 388-101-1870, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-520, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-520, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1880 Who is responsible for completing and overseeing a client's ISP/POC? [05-05-077, recodified as § 388-101-1880, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-530, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-530, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-1890 Who may participate in creating a client's ISP/POC? [05-05-077, recodified as § 388-101-1890, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-540, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-540, filed 10/26/01, effective 1/1/02.]

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| | Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2090 | How does a service provider manage client funds? [05-05-077, recodified as § 388-101-2090, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-640, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-1900 | How often must the ISP/POC be reviewed? [05-05-077, recodified as § 388-101-1900, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-550, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-550, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-550, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2100 | What documentation must service providers keep to protect a client's financial interests? [05-05-077, recodified as § 388-101-2100, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-650, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-650, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-650, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2000 | What plans must crisis diversion service providers develop? [05-05-077, recodified as § 388-101-2000, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-555, filed 1/29/04, effective 2/29/04.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2110 | How are a client's funds transferred when they are managed by a service provider? [05-05-077, recodified as § 388-101-2110, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-660, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2010 | What is an individual instruction and support plan (IISP) for clients? [05-05-077, recodified as § 388-101-2010, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-560, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-560, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-560, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2120 | How does a service provider handle loans to a client? [05-05-077, recodified as § 388-101-2120, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-670, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2020 | Who may participate in developing the IISP for each client? [05-05-077, recodified as § 388-101-2020, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-570, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2130 | When must a service provider pay a client? [05-05-077, recodified as § 388-101-2130, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-680, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2030 | Who oversees the IISP for each client? [05-05-077, recodified as § 388-101-2030, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-580, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2140 | What must service providers do to support a client's health? [05-05-077, recodified as § 388-101-2140, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-690, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-690, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2040 | May a service provider manage a client's funds? [05-05-077, recodified as § 388-101-2040, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-590, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2150 | May a client refuse health care services? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-2150, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-2150, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-700, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2050 | May a service provider hold bankbooks and bankcards for a client? [05-05-077, recodified as § 388-101-2050, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-600, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-600, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2160 | When may client funds be used for health services? [05-05-077, recodified as § 388-101-2160, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-710, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2060 | May a service provider combine agency and client funds? [05-05-077, recodified as § 388-101-2060, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-610, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2300 | Client transportation. [Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-2300, filed 8/29/06, effective 10/1/06. 05-05-077, recodified as § 388-101-2300, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-720, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-720, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2070 | Does the service provider need to develop an individual financial plan (IFP) for clients? [05-05-077, recodified as § 388-101-2070, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-620, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2330 | May an agency or service provider contest a RCS decision? [05-05-077, recodified as § 388-101-2330, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-880, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-880, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. |
| 388-101-2080 | What information must the IFP include? [05-05-077, recodified as § 388-101-2080, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-630, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-630, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW. | 388-101-2340 | When does an administrative review conference occur? [05-05-077, recodified as § 388-101-2340, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW |

- 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-890, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-890, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2350 May an administrative review conference be conducted by telephone? [05-05-077, recodified as § 388-101-2350, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-900, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-900, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2360 What happens during the administrative review conference? [05-05-077, recodified as § 388-101-2360, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-910, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-910, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2370 May an agency or service provider contest the decision from the administrative review conference? [05-05-077, recodified as § 388-101-2370, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-920, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-920, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2380 Does RCS make exceptions to the requirements in this chapter? [05-05-077, recodified as § 388-101-2380, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-930, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-930, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2400 Who may delegate nursing care tasks? [05-07-138, recodified as § 388-101-2400, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-730, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2410 What training is required before staff are qualified to perform delegated tasks? [Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-2410, filed 5/3/05, effective 6/3/05. 05-07-138, recodified as § 388-101-2410, filed 3/22/05, effective 3/22/05. 05-05-077, recodified as § 388-101-2310, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-740, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2420 Do nursing assistants need to comply with department of health requirements? [05-07-138, recodified as § 388-101-2420, filed 3/22/05, effective 3/22/05. 05-05-077, recodified as § 388-101-2320, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-750, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2430 Who is authorized to provide consent for a client's receiving health care? [05-07-138, recodified as § 388-101-2430, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-760, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2440 What rights do nursing assistants have concerning the delegation of nursing care tasks? [05-07-138, recodified as § 388-101-2440, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-770, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2450 Are nursing assistants liable for errors while doing nursing care tasks? [05-07-138, recodified as § 388-101-2450, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-780, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2460 What happens if unqualified staff do a nursing task? [05-07-138, recodified as § 388-101-2460, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-790, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2470 What technical assistance may service providers get from DSHS for nurse delegation requirements? [05-07-138, recodified as § 388-101-2470, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-800, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2480 What happens when DSHS finds a service provider in violation of nurse delegation requirements? [05-07-138, recodified as § 388-101-2480, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-810, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2490 May a service provider have a chance to correct violations before being fined? [05-07-138, recodified as § 388-101-2490, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-820, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2500 May civil fines be imposed during technical assistance visits? [05-07-138, recodified as § 388-101-2500, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-830, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2510 How does DSHS impose a civil fine? [05-07-138, recodified as § 388-101-2510, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-840, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2520 When is payment due for a civil fine? [05-07-138, recodified as § 388-101-2520, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-850, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2530 May a service provider disagree with DSHS findings of a violation? [05-07-138, recodified as § 388-101-2530, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-860, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.
- 388-101-2540 May a service provider contest a civil fine? [05-07-138, recodified as § 388-101-2540, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-870, filed 10/26/01, effective 1/1/02.] Repealed by 08-02-022, filed 12/21/07, effective 2/1/08. Statutory Authority: Chapter 71A.12 RCW.

WAC 388-101-3000 Definitions. "Abandonment"

means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means:

(1) The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult;

(2) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish; and

(3) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **"Sexual abuse"** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

(b) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing and certification requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Case manager" means the division of developmental disabilities case resource manager or social worker assigned to a client.

"Certification" means a process used by the department to determine if an applicant or service provider complies with the requirements of this chapter and is eligible to provide certified community residential services and support to clients.

"Chaperone agreement" means a plan or agreement that describes who will supervise a community protection program client when service provider staff is not present. This plan or agreement is negotiated with other agencies and individuals who support the client, including the client's legal representative and family.

"Chemical restraint" means the use of psychoactive medications for discipline or convenience and not prescribed to treat the client's medical symptoms.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) and who also has been determined eligible to receive services by the division of developmental disabilities under chapter 71A.16 RCW. For purposes of informed consent and decision making requirements, the term "client" includes the client's legal representative to the extent of the representative's legal authority.

"Client services" means instruction and support services that service providers are responsible to provide as identified in the client's individual support plan.

"Crisis diversion" means temporary crisis residential services and supports provided to clients at risk of psychiatric

hospitalization and authorized by the division of developmental disabilities.

"Crisis diversion bed services" means crisis diversion that is provided in a residence maintained by the service provider.

"Crisis diversion support services" means crisis diversion that is provided in the client's own home.

"Department" means the Washington state department of social and health services.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage other than the vulnerable adult's profit or advantage.

"Functional assessment" means a comprehensive evaluation of a client's challenging behavior(s). This evaluation is the basis for developing a positive behavior support plan.

"Group home" means a residence that is licensed as either a boarding home or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

"Group training home" means a certified nonprofit residential facility that provides full-time care, treatment, training, and maintenance for clients, as defined under RCW 71A.22.020(2).

"Immediate" or **"immediately"** means within twenty-four hours for purposes of reporting abandonment, abuse, neglect, or financial exploitation of a vulnerable adult.

"Individual financial plan" means a plan describing how a client's funds will be managed when the service provider is responsible for managing any or all of the client's funds.

"Individual instruction and support plan" means a plan developed by the service provider and the client. The individual instruction and support plan:

(1) Uses the information and assessed needs documented in the individual support plan to identify areas the client would like to develop;

(2) Includes client goals for instruction and support that will be formally documented during the year; and

(3) Must contain or refer to other applicable support or service information that describes how the client's health and welfare needs are to be met (e.g. individual financial plan, positive behavior support plan, cross system crisis plan, individual support plan, individual written plan, client-specific instructions).

"Individual support plan" means a document that authorizes and identifies the division of developmental disabilities paid services to meet a client's assessed needs.

"Instruction" means goal oriented teaching that is designed for acquiring and enhancing skills.

"Legal representative" means a person's legal guardian, a person's limited guardian when the subject matter is within the scope of the limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Managing client funds" means that the service provider:

(1) Has signing authority for the client;

(2) Disperses the client's funds; or

(3) Limits the client's access to funds by not allowing funds to be spent.

"Mechanical restraint" means a device or object, which the client cannot remove, applied to the client's body that restricts his/her free movement.

"Medication administration" means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

"Medication assistance" means assistance with self administration of medication rendered by a nonpractitioner to a client receiving certified community residential services and supports in accordance with chapter 69.41 RCW and chapter 246-888 WAC.

"Medication service" means any service provided by a certified community residential services and support provider related to medication administration or medication assistance provided through nurse delegation and medication assistance.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Physical intervention" means the use of a manual technique intended to interrupt or stop a behavior from occurring. This includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

"Physical restraint" means physically holding or restraining all or part of a client's body in a way that restricts the client's free movement. This does not include briefly holding, without undue force, a client in order to calm him/her, or holding a client's hand to escort the client safely from one area to another.

"Psychoactive" means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

"Psychoactive medications" means medications prescribed to improve or stabilize mood, mental status or behavior. Psychoactive medications include anti-psychotics/neuroleptics, atypical antipsychotics, antidepressants, stimulants, sedatives/hypnotics, and antimania and antianxiety drugs.

"Qualified professional" means a person with at least three years' experience working with individuals with developmental disabilities and as required by RCW 71A.12.220 (12).

"Restrictive procedure" means any procedure that restricts a client's freedom of movement, restricts access to client property, requires a client to do something which he/she does not want to do, or removes something the client owns or has earned.

"Risk assessment" means an assessment done by a qualified professional and as required by RCW 71A.12.230.

"Service provider" means a person or entity certified by the department who delivers services and supports to meet a client's identified needs. The term includes the state operated living alternative (SOLA) program.

"Support" means assistance a service provider gives a client based on needs identified in the individual support plan.

"Supported living" means instruction, supports, and services provided by service providers to clients living in homes that are owned, rented, or leased by the client or their legal representative.

"Treatment team" means the program participant and the group of people responsible for the development, implementation, and monitoring of the person's individualized supports and services. This group may include, but is not limited to, the case manager, therapist, the service provider, employment/day program provider, and the person's legal representative and/or family, provided the person consents to the family member's involvement.

"Vulnerable adult" includes a person:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(2) Found incapacitated under chapter 11.88 RCW; or

(3) Who has a developmental disability as defined under RCW 71A.10.020; or

(4) Admitted to any facility; or

(5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(6) Receiving services from an individual provider.

"Willful" means the deliberate, or nonaccidental, action or inaction by an alleged perpetrator that he/she knew or reasonably should have known could cause a negative outcome, harm, injury, pain, and anguish.

"Written individual plan" means a plan developed for clients in the community protection program that includes:

(1) An assessment of the client's emotional and behavioral issues as related to community protection risks;

(2) Specific intervention strategies and techniques related to community protection risks;

(3) Specific restrictions and measures, including security precautions, both in-home and out-of-home; and

(4) Signatures of the client's case manager and the client.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3000, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3010 Certified community residential services and supports. In order for a person or entity to deliver client instruction and support services under this chapter the person or entity must:

(1) Be certified by the department; and

(2) Be granted a contract by the department.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3010, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3020 Compliance. The service provider must be in compliance with:

(1) All the requirements of this chapter. Except that, the licensing requirements for adult family homes and boarding homes supersede this chapter if the requirements under

respective chapters 388-76 and 388-78A WAC conflict with this chapter;

(2) The laws governing this chapter, including chapter 71A.12 and 71A.22 RCW;

(3) The requirements of chapter 74.34 RCW;

(4) The department's residential services contract. Except that, the requirements of this chapter supersede any conflicting requirements with the contract, or appendices to the contract; and

(5) Other relevant federal, state and local laws, requirements, and ordinances.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3020, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3030 Application required. (1) A person or entity must complete an application before the department will consider initial certification; and

(2) The service provider must complete an application before the department will consider a request for change of ownership as detailed in WAC 388-101-3060.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3030, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3040 Residential services contract. (1) The service provider may request a department residential services contract after approval for initial certification or for change of ownership.

(2) The service provider must have a separate contract for each region where they receive referrals to serve clients.

(3) The service provider's residential services contract will be terminated by the department upon termination of certification.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3040, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3050 Application for initial certification. (1) To apply for initial certification an applicant must submit to the department:

(a) A letter of intent that includes:

(i) Contact information;

(ii) Geographical area of service; and

(iii) Type of service provided, including group home, supported living, community protection, or group training home.

(b) A completed and signed application on forms designated by the department;

(c) All attachments specified in the application and any other information the department may request including but not limited to:

(i) Administrator resumes;

(ii) Statements of financial stability;

(iii) Professional references;

(iv) Relevant experiences and qualifications of the individual or agency; and

(v) Assurances the applicant will not discriminate against any client or employee.

(d) A copy of the license if applying for certification as a group home;

(e) The name of the administrator of the program; and

(f) Department criminal history background check on forms designated by the department for the individual or individuals designated to serve as administrator of the proposed program.

(2) The applicant must submit a revised application, if any information on the application changes before the initial certification is issued.

(3) The department will only process a completed application.

(4) Each person named in the application for initial certification is considered separately and jointly by the department.

(5) Based on the documentation received, the department will notify the applicant in writing regarding the department's certification decision.

(6) The applicant must comply with additional requirements identified in this chapter if intending to support community protection clients.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3050, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3060 Change of ownership. (1) To apply for a change of ownership, an applicant must submit an application and the required reports and documents to the department when there is a change of:

(a) The business entity ownership; or

(b) The form of legal organization.

(2) The service provider applying for a change of ownership may be required to provide any or all items listed in WAC 388-101-3050.

(3) If the applicant is not a current service provider, the applicant must apply for initial certification.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3060, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3070 Notice for change of ownership. The current service provider must notify:

(1) The department in writing sixty days before a change of ownership; and

(2) Clients or their legal representatives in writing thirty days before a change of ownership.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3070, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3080 The department may deny—Application. The department may deny the application for initial certification or change of ownership if any person named in the application:

(1) Has shown a lack of understanding, ability or emotional stability to meet the identified needs of vulnerable adults;

(2) Had a department contract, certification, or license withdrawn or denied by the department, or has been subjected to enforcement actions;

(3) Had a contract, certification, or license withdrawn or denied or was subjected to enforcement action in another state;

(4) Obtained or attempted to obtain a license or certification by fraudulent means or misrepresentation;

(5) Has relinquished or been denied a license or license renewal to operate a home or facility that was licensed for the care of children or vulnerable adults;

(6) Refused to permit authorized department representatives to interview clients or to have access to client records;

(7) Has been convicted of a drug related conviction within the past five years without evidence of rehabilitation; or

(8) Has been convicted of an alcohol related conviction within the past five years without evidence of rehabilitation.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3080, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3090 The department must deny—

Application. The department must deny an application for initial certification or change of ownership if any person named in the application was:

(1) Convicted of a crime against children or other persons or crimes relating to financial exploitation as defined under RCW 43.43.830 or 43.43.842;

(2) Found by a court in a protection proceeding or in a civil damages lawsuit under chapter 74.34 RCW to have abused, neglected, abandoned or financially exploited a vulnerable adult;

(3) Found in any dependency action under chapter 13.34 RCW to have sexually assaulted, neglected, exploited, or physically abused any minor;

(4) Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused, exploited, or physically abused any minor;

(5) Found in any final decision issued by a disciplinary board to have sexually or physically abused or exploited any minor or have abused, neglected, abandoned, or financially exploited any vulnerable adult as defined under chapter 74.34 RCW; or

(6) The subject of a stipulated finding of fact, conclusion of law, an agreed order, finding of fact, final order issued by a disciplining authority or final decision by any federal or state agency or department, a court of law, or entered into a state registry or department or agency list with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3090, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3100 Certification—Initial. (1) The department may approve the individual or entity for initial certification when the individual or entity complies with the requirements of this chapter. The department may:

(a) Grant initial certification for up to one hundred and eighty days of the effective date of the residential services contract; and

(b) Extend initial certification for an additional period up to one hundred and eighty days.

(2) If an applicant does not receive a residential services contract, initial certification will be valid for up to one year.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3100, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3110 Certification—Regular. (1) The department may approve the service provider for regular certification when the service provider complies with the requirements of this chapter and the residential services contract. The department may:

(a) Grant certification to a service provider for up to two years; and

(b) Extend regular certification for an additional period up to one hundred and eighty days.

(2) If a service provider does not comply with the certification requirements, the department may provisionally certify or decertify a service provider.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3110, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3130 Certification evaluation. (1) The department may conduct an on-site certification evaluation of each service provider at any time, but at least once every two years.

(2) During certification evaluations the service provider's administrator or designee must:

(a) Cooperate with department representatives during the on-site visit;

(b) Provide all contractor records, client records, and other relevant information requested by the department representatives;

(c) Ensure the service provider's administrator or designee is available during any visit to respond to questions or issues identified by department representatives; and

(d) Ensure the service provider's administrator or designee is present at the exit conference.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3130, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3140 Complaint investigation. The department may conduct unannounced complaint investigations to determine the service provider's compliance with this chapter, the residential services contract, and applicable laws and requirements.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3140, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3150 State and federal access to program. The service provider must:

(1) Allow any state or federal department or agency to conduct audits, evaluations, or complaint investigations related to this program or to clients served in this program;

(2) Allow department representatives to review a client's records and activities at any time to see if the service provider continues to address the clients' needs for instruction and support activities;

(3) Allow the department representatives' access to clients, the client's legal representative and family members;

(4) Cooperate with department representatives in the performance of official duties; and

(5) Allow access to clients and client records by an advocacy group if the advocacy group has access authority under state or federal law.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3150, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3160 Plan of correction. The service provider must:

(1) Submit a signed plan of correction to the department according to established department processes and timelines; and

(2) Include in the plan of correction:

(a) What the service provider did or will do to correct each deficiency;

(b) How the service provider will prevent future problems of this type;

(c) Who will be responsible for monitoring the corrections to ensure the problems do not recur; and

(d) When lasting correction will be achieved.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3160, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3170 Group training home. After the effective date of this chapter a person or entity desiring to become a group training home must:

(1) Complete an application on forms and attachments designated by the department; and

(2) Currently be:

(a) Certified as a community residential services and support provider;

(b) Licensed as an adult family home under chapter 70.128 RCW; and

(c) A nonprofit business in accordance with state and federal law.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3170, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3180 Department approval of group training home status. The department will consider, at a minimum, the following when determining whether to approve or deny an application for group training home status:

(1) The needs of the program;

(2) Available funding;

(3) The information received from the applicant;

(4) The certification history of the applicant;

(5) The licensing history of the applicant; and

(6) The capacity of the home.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3180, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3190 Service provider responsibilities. (1) Service providers must meet the requirements of:

(a) This chapter;

(b) Each contract and statement of work entered into with the department;

(c) Each client's individual support plan when the individual support plan identifies the service provider as responsible; and

(d) Each client's individual instruction and support plan.

(2) The service provider must:

(a) Have a designated administrator and notify the department when there is a change in administrator;

(b) Ensure that clients have immediate access to staff, or the means to contact staff, at all times;

(c) Provide adequate staff within contracted hours to administer the program and meet the needs of clients;

(d) Not routinely involve clients in the unpaid instruction and support of other clients;

(e) Not involve clients receiving crisis diversion services in the instruction and support of other clients; and

(f) Retain all records and other material related to the residential services contract for six years after expiration of the contract.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3190, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3200 Staffing requirements. The service provider must ensure each staff meets the following minimum requirements:

(1) Have a high school diploma or GED equivalent, unless the employees were hired before September 1, 1991;

(2) Be at least eighteen years of age or older when employed as a direct care staff, or at least twenty-one years of age or older when employed as an administrator;

(3) Have a clear understanding of job responsibilities and knowledge of individual support plans and client needs; and

(4) Passed the department background check as required by WAC 388-101-3250.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3200, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3210 Administrative documents. The service provider must prepare and maintain written documents as follows:

(1) A mission statement;

(2) A program description;

(3) An organizational chart and description showing all supervisory relationships;

(4) Description of staff roles and responsibilities, including the person designated to act in the absence of the administrator; and

(5) Staffing schedules.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3210, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3220 Administrator responsibilities. The service provider must ensure that the administrator delivers services to clients consistent with this chapter, and the department's residential services contract. This includes but is not limited to:

(1) Overseeing all aspects of staffing, such as recruitment, staff training, and performance reviews;

(2) Developing and maintaining policies and procedures that give staff direction to provide appropriate services and support as required by this chapter and the department contract; and

(3) Maintaining and securely storing client, personnel, and financial records.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3220, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3230 Group homes. A service provider who is a licensed adult family home or boarding home must:

(1) Provide care and services in accordance with this chapter and with licensing requirements under chapters 388-76 and 388-78A WAC respectively;

(2) Comply with client rights requirements in chapter 70.129 RCW and this chapter;

(3) Comply with the home's licensing requirements if there is a conflict with requirements in this chapter; and

(4) Comply with this chapter if the requirement is over and above the home's licensing requirements.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3230, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3240 Policies and procedures. (1) The service provider must develop, implement, and train staff on policies and procedures to address what staff must do:

(a) Related to client rights, including a client's right to file a complaint or suggestion without interference;

(b) Related to soliciting client input and feedback on instruction and support received;

(c) Related to reporting suspected abuse, neglect, financial exploitation, or abandonment;

(d) To protect clients when there have been allegations of abuse, neglect, financial exploitation, or abandonment;

(e) In emergent situations that may pose a danger or risk to the client or others, such as in the event of death or serious injury to a client;

(f) In responding to missing persons and client emergencies;

(g) Related to emergency response plans for natural or other disasters;

(h) When accessing medical, mental health, and law enforcement resources for clients;

(i) Related to notifying a client's legal representative, and/or relatives in case of emergency;

(j) When receiving and responding to client grievances; and

(k) To respond appropriately to aggressive and assaultive clients.

(2) The service provider must develop, implement, and train staff on policies and procedures in all aspects of the medication support they provide, including but not limited to:

(a) Supervision;

(b) Client refusal;

(c) Services related to medications and treatments provided under the delegation of a registered nurse consistent with chapter 246-840 WAC;

(d) The monitoring of a client who self-administers their own medications;

(e) Medication assistance for clients needing this support; and

(f) What the service provider will do in the event they become aware that a client is no longer safe to take their own medications.

(3) The service provider must maintain current written policies and procedures and make them available to all staff; and to clients and legal representatives upon request.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3240, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3250 Background checks. (1) The service provider must obtain background checks including, but not limited to background inquiries and criminal history disclosure from the department for all administrators, employ-

ees, volunteers, and subcontractors who may have unsupervised access to clients.

(2) The service provider must not allow the following persons to have unsupervised access to clients until the service provider receives successful background check results from the department:

(a) Administrators;

(b) Employees;

(c) Volunteers or students; and

(d) Subcontractors.

(3) Service providers or applicants who have lived in Washington state less than three years or who are otherwise required to complete a fingerprint-based background check may be hired for a one hundred twenty-day provisional period as allowed under law when:

(a) The applicant or service provider is not disqualified based on the initial result of the background check from the department; and

(b) A fingerprint-based background check is pending.

(4) The service provider must notify the person, within ten days of receiving the result, that he or she may request a copy of the background check.

(5) The service provider must renew the background check at least every thirty-six months and keep current department background checks for each administrator, employee, volunteer or subcontractor of a service provider.

(6) Licensed boarding homes or adult family homes must adhere to the current regulations in this chapter and in the applicable licensing laws.

(7) Service providers must follow the requirements of RCW 43.43.830 through 43.43.842 and RCW 74.15.030.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3250, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3260 Staff training. The service provider must:

(1) Provide and document required training to staff;

(2) Within the first six months, ensure that staff receives a minimum of thirty-two total hours of training that meets the training requirements of this chapter;

(3) Provide staff training sooner if required by the client's identified needs; and

(4) Meet state and federal laws regarding training; such as, bloodborne pathogens training referenced in WAC 296-823-120.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3260, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3270 Staff training before working alone with clients. The service provider must train staff in the following before the employee works alone with clients:

(1) Current individual instruction and support plans of each client with whom the employee works;

(2) Emergency procedures for clients;

(3) The reporting requirements for abuse and neglect under chapter 74.34 RCW; and

(4) Client confidentiality.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3270, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3280 Staff training within four weeks of employment. The service provider must provide training within the first four weeks of employing a staff person to include:

- (1) The service provider's mission statement;
- (2) Policies and procedures; and
- (3) On-the-job training.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3280, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3290 Staff training within six months of employment. The service provider must provide training within the first six months of employing a staff person, to include:

- (1) First aid and CPR;
- (2) Bloodborne pathogens with HIV/AIDS information;
- (3) Client services;
- (4) Residential guidelines; and
- (5) Positive behavior support.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3290, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3300 Staff training to be current. The service provider must ensure that each employee keeps their first-aid training, CPR certification, and bloodborne pathogens training current.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3300, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3310 Approval of staff-coverage schedules. (1) The service provider must obtain division of developmental disabilities approval of schedules to provide twenty-four hour support, at the following times:

- (a) Prior to certification review;
- (b) When household configuration changes affect staff coverage; or
- (c) When additional staffing is requested or needed by the client.

(2) The service provider must retain copies of the staff coverage schedules.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3310, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3320 Client rights. Clients have the same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution, federal and state law unless limited through legal processes. Service providers must promote and protect all of the following client rights, including but not limited to:

- (1) The right to be free from discrimination;
- (2) The right to be reasonably accommodated in accordance with state and federal law;
- (3) The right to privacy, including the right to receive and send private mail and telephone calls;
- (4) The right to participate in an appropriate program of publicly supported education;
- (5) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment, and financial exploitation; and
- (6) The right to refuse health services, medications, restraints, and restrictions.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3320, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3330 Treatment of clients. Service providers must treat clients with dignity and consideration, respecting the client's civil and human rights at all times.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3330, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3340 Subcontracting. The service provider must not subcontract any service without prior written approval from the department. The service provider must ensure that all required terms, conditions, assurances and certifications are included in all subcontracts.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3340, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3350 Residential guidelines. The service provider must use the following department residential guidelines when providing services to each client:

- (1) Health and safety;
- (2) Personal power and choice;
- (3) Competence and self-reliance;
- (4) Positive recognition by self and others;
- (5) Positive relationships; and
- (6) Integration in the physical and social life of the community.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3350, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3360 Client services. Service providers must provide each client instruction and/or support to the degree the individual support plan identifies the service provider as responsible. Instruction and/or support to the client may include but are not limited to the following categories:

- (1) Home living activities;
- (2) Community living activities;
- (3) Life-long learning activities;
- (4) Health and safety activities;
- (5) Social activities;
- (6) Employment;
- (7) Protection and advocacy activities;
- (8) Exceptional medical support needs; and
- (9) Exceptional behavioral support needs.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3360, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3370 Client health services support. The service provider must provide instruction and/or support as identified in the individual support plan and as required in this chapter to assist the client with:

- (1) Accessing health, mental health, and dental services;
- (2) Medication management, administration, and assistance;
- (3) Maintaining health records;
- (4) Arranging appointments with health professionals;
- (5) Monitoring medical treatment prescribed by health professionals;
- (6) Communicating directly with health professionals when needed; and

(7) Receiving an annual physical and dental examination unless the appropriate medical professional gives a written exception.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3370, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3375 Nurse delegation. (1) Service provider staff must not perform a delegated nursing task for the client before the delegating nurse has obtained consent from the client or person authorized to give consent.

(2) The service provider must not allow an employee to perform any nursing task that violates applicable statutes and rules, including:

- (a) Chapter 18.79 RCW, Nursing care;
- (b) Chapter 18.88A RCW, Nursing assistants;
- (c) Chapter 246-840 WAC, Practical and registered nursing;
- (d) Chapter 246-841 WAC, Nursing assistants; and
- (e) Chapter 246-888 WAC, Medication assistance.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3375, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3380 Client transportation. (1) The service provider must meet the client's transportation needs by:

- (a) Not charging the client for transportation costs except as specified in the client's individual support plan;
- (b) Using the client's Medicaid coupons for covered transportation, if available; and
- (c) Ensuring that other transportation is provided as specified in the client's individual support plan.

(2) The service provider must provide transportation or ensure that clients have a way to get to and from:

- (a) Emergency medical care;
- (b) Medical appointments; and
- (c) Therapies.

(3) As specified in the client's individual support plan, the service provider must provide necessary assistance with transportation to and from:

- (a) School or other publicly funded services;
- (b) Work;
- (c) Leisure or recreation activities; and
- (d) Client-requested activities.

(4) A vehicle that the service provider uses to transport clients must be insured as required by chapters 46.29 and 46.30 RCW.

(5) The service provider must maintain a business automobile insurance policy on service provider owned vehicles used to transport clients.

(6) The service provider must maintain nonowned vehicle insurance coverage for vehicles not owned by the service provider but used to transport clients.

(7) Service providers, employees, subcontractors, and volunteers who transport clients must have a valid driver's license as required by chapter 46.20 RCW.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3380, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3390 Physical and safety requirements. (1) Crisis diversion support service providers are exempt from the requirements in this section.

(2) The service provider must ensure that the following home safety requirements are met for each client unless otherwise specified in the client's individual support plan:

- (a) A safe and healthy environment;
- (b) Accessible telephone equipment and a list of emergency contact numbers;
- (c) An evacuation plan developed and practiced with the client;
- (d) Unblocked door and window for emergency exit;
- (e) A safe storage area for flammable and combustible materials;
- (f) An operating smoke detector, with a light alarm for clients with hearing impairments;
- (g) An accessible flashlight or other safe accessible light source in working condition; and
- (h) Basic first-aid supplies.

(3) The service provider must assist clients in regulating household water temperature unless otherwise specified in the client's individual support plan as follows:

- (a) Maintain water temperature in the household no higher than one hundred and twenty degrees Fahrenheit;
- (b) Check water temperature when the client first moves into the household and at least once every three months from then on; and
- (c) Regulate water temperature for clients who receive twenty-four hour support, and for other clients as specified in the individual support plan.

(4) The service provider must document and keep records that indicate that physical safety requirements are met for each client.

(5) A client may independently document these requirements are met when the client's individual support plan specifies this level of client involvement.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3390, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3400 Services to nonclients. Before providing services to nonclients in the same household with clients, the service provider must:

- (1) Provide the department with a written description of the household composition;
- (2) Obtain written approval from the division of developmental disabilities; and
- (3) Obtain written consent from each client in the household or the client's legal representative if the client is unable to consent.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3400, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3410 Community protection clients and other clients in the same household. Before allowing a community protection program client to live in the same household with supported living clients who are not in the community protection program, the service provider must:

- (1) Provide the department with a written description of the household composition;
- (2) Participate with the treatment team during the household composition review;

(3) Obtain written approval from the division of developmental disabilities; and

(4) Obtain written consent from each client in the household or the client's legal representative if the client is unable to consent.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3410, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3420 Client refusal to participate in services. (1) The service provider must notify the case manager if the client's health and safety is adversely affected by the client's refusal to participate in services.

(2) Service providers must document each client's refusal to participate in:

(a) Physical and safety requirements, as outlined in WAC 388-101-3390; and

(b) Client health services support under WAC 388-101-3370.

(3) Service providers must document the following:

(a) A description of events relating to the client's refusal to participate in these services;

(b) That the client was informed of the benefits of these services and the possible risks of refusal;

(c) A description of the service provider's efforts to give or acquire the services for the client; and

(d) Any health or safety concerns that the refusal may pose.

(4) The service provider must:

(a) Review this documentation with the client or the client's legal representative at least every six months; and

(b) Request that the client or client's legal representative sign and date the document after reviewing it.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3420, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3430 Changes in client service needs—Nonemergent. The service provider must notify the department:

(1) When a client's service needs change and the individual support plan no longer addresses the client's needs; and

(2) May request in writing, assistance from the department's case manager in setting up an assessment meeting.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3430, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3440 Changes in client service needs—Emergent. (1) The service provider must promptly notify the department to ask for emergency assistance when a client's needs change and the actions or continued presence of the client endangers the health, safety and/or personal property of other clients, the client, those working with the client, or other public citizens.

(2) If further assistance is needed following the department's initial response, the service provider must confirm in writing to the client's case manager on the first working day after initiating a verbal request for such assistance:

(a) The nature of the emergency;

(b) The need for immediate assistance and the specific type of assistance needed; and

(c) The specific type of assistance needed.

(3) When the emergency cannot be resolved and the service provider wants to terminate services to the client, the service provider must:

(a) Notify the department in writing;

(b) Specify the reasons for terminating services to the client; and

(c) Ensure that the department receives the notice at least seventy-two hours before moving the client from the program.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3440, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3450 Service provider refusal to serve a client. (1) The service provider may refuse services to a client when the service provider has determined and documented:

(a) Why the provider cannot meet the client's needs; or

(b) How the provider's refusal to serve the client would be in the best interest of the client or other clients.

(2) Before terminating services to the client, the service provider must notify the department, the client and the client's legal representative in writing ten working days before terminating services.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3450, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3460 Individual support plan. The service provider must use the client's current individual support plan in the development of the individual instruction and support plan.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3460, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3470 Development of the individual instruction and support plan. (1) The service provider must develop and implement an individual instruction and support plan for each client that incorporates the department's residential guidelines in developing instruction and support activities.

(2) In developing the individual instruction and support plan, the service provider must:

(a) Work with the client to develop goals based on the individual support plan that will be worked on during the implementation of the individual instruction and support plan for the upcoming year;

(b) Identify how the instruction and/or support activities will be provided to meet the assessed needs of the client as described in the individual support plan;

(c) Ensure that the individual instruction and support plan contains or refers to other applicable support and/or service information; and

(d) Include the participation and agreement of the client and other individuals the client wants included.

(3) The service provider must send a copy of the individual instruction and support plan goals together with a list of applicable support and service information and where the information is located to the case manager for review.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3470, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3480 Documentation of the individual instruction and support plan. For each client the service provider must:

- (1) Develop and keep a written record of the individual instruction and support plan that includes the elements required in WAC 388-101-3470;
- (2) Include a section or page in the individual instruction and support plan that provides or references all applicable support or service information pertaining to the client;
- (3) Review and update the plan to reflect changes in the assessed needs as described in the individual support plan;
- (4) Sign and date the plan's documents; and
- (5) Document the client's agreement with the plan as well as the client's legal representative if applicable.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3480, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3490 Implementation of the individual instruction and support plan. The service provider must:

- (1) Oversee the progress made on each client's individual instruction and support plan;
- (2) Coordinate with other staff, and other providers serving the client, and other interested persons as needed, in implementing the individual instruction and/or support plan; and
- (3) Revise and update the plan as the client's assessed needs change.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3490, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3500 Accessibility of the individual instruction and support plan. The service provider must make the individual instruction and support plan accessible at all times to:

- (1) Staff to provide direction on what they are to do to instruct and/or support the client;
- (2) The client receiving service;
- (3) The client's legal representative; and
- (4) Representatives of the department.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3500, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3510 Ongoing updating of the individual instruction and support plan. The service provider must:

- (1) Review and revise the individual instruction and support plan as goals are achieved or as client assessed needs change in order to reflect the client's current needs, goals, and preferences:
 - (a) At least semi-annually; and
 - (b) At any time requested by the client or the client's legal representative.
- (2) Send an updated copy of the instruction and support goals of the individual instruction and support plan and the list of applicable support and service information and where the information is located to the case manager for review.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3510, filed 12/21/07, effective 2/1/08.]

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WAC 388-101-3520 Client related funds. If the service provider does not manage the client's funds and receives funds for the client from any source, the service provider must be able to show that all the funds received are:

- (1) Given to the client or the client's legal representative;
- (2) Deposited to the client's account; or
- (3) Used only for the client.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3520, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3530 Individual financial plan. (1) The service provider must develop and implement an individual financial plan with client participation when the client's individual support plan:

- (a) Identifies that the client needs support to manage funds; and
 - (b) Designates the service provider as responsible for that support; or
 - (c) Indicates the service provider manages any portion of the client's funds.
- (2) The service provider must obtain signatures from the client and the client's legal representative on the individual financial plan.
- (3) The service provider must include the following in the client's individual financial plan:
- (a) Client funds and income managed by the service provider;
 - (b) Client funds and income managed by the client and the client's legal representative;
 - (c) The type of accounts containing client funds;
 - (d) A description of how the client's funds will be spent during a typical month;
 - (e) Money management instruction or support provided to the client; and
 - (f) If applicable, asset management including such things as personal property, burial plan, retirement funds, stock, and vehicles.
- (4) The service provider must review the individual financial plan with the client at least every twelve months.
- (5) The service provider must send a copy of each client's individual financial plan to:
- (a) The client's legal representative; and
 - (b) The client's case manager upon request.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3530, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3540 Managing client funds. (1) Before managing a client's funds the service provider must either:

- (a) Obtain written consent from the client or the client's legal representative; or
 - (b) Become the representative payee.
- (2) For any client funds managed by the service provider, the service provider must:
- (a) Separately track each client's money, even when several clients reside together;
 - (b) Maintain a current running balance of each client account;
 - (c) Make deposits to the client's bank account within one week of receiving the client's money;

(d) Prevent the client's bank account from being overdrawn;

(e) Ensure that client cash funds do not exceed seventy-five dollars per client unless specified differently in the individual financial plan; and

(f) Retain receipts for each purchase over twenty-five dollars.

(3) Social Security Administration requirements for managing the client's Social Security income take precedence over these rules if:

(a) The service provider is the client's representative payee; and

(b) The Social Security Administration requirement conflicts with these rules.

(4) When the service provider manages the client's funds and receives a check made out to the client, the service provider must:

(a) Get the client's signature and designation "for deposit only"; or

(b) Get the client's "x" mark in the presence of a witness and cosign the check with the designation "for deposit only"; and

(c) Deposit the check in the client's bank account as required under subsection (2)(c) of this section.

(5) If a check for the client is made out to a payee other than the client, the service provider must ask the payee to sign the check.

(6) The service provider must not ask the client to sign a blank check.

(7) The service provider may only assist the client to make purchases by check when the client signs the check at the time of the purchase unless:

(a) Otherwise specified in the client's individual financial plan; or

(b) The service provider is the client's representative payee.

(8) The service provider must document in the client's record the name of each staff that may assist the client with financial transactions.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3540, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3545 Using client funds for health services. The service provider must document all denials for client health services from the department's medical assistance administration, and medical insurance companies. The service provider:

(1) Must notify the case manager of the denial in writing; and

(2) May use client funds for the client's health services if no other funding is available.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3545, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3550 Reconciling and verifying client accounts. (1) For any client funds managed by the service provider, the service provider must:

(a) Reconcile the client's bank accounts to the client's bank statements each month;

(b) Reconcile the client's cash account each month; and

(c) Verify the accuracy of the reconciliation.

(2) The service provider must not allow the same staff person to do both the verification and reconciliation of the client's account.

(3) The service provider must ensure that the verification or reconciliation is done by a staff person who did not:

(a) Make financial transactions on the client's behalf; or

(b) Assist the client with financial transactions.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3550, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3560 Combining service provider and client funds. The service provider must not combine client funds with any service provider funds, such as agency operating funds.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3560, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3570 Client bankbooks and bankcards. (1) For clients who manage their own funds, the service provider must document in the client's record when the client asks the provider to hold the client's bankbooks and bankcards.

(2) When the service provider holds the client's bankcards or bankbooks as requested by the client:

(a) It is not assumed that the service provider is managing the client's funds; and

(b) The client must continue to have access to his or her own funds.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3570, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3580 Client financial records. (1) For client funds that the service provider manages, the service provider must retain documentation including documentation for bank and cash accounts.

(2) The service provider must also keep the following documentation for client financial transactions:

(a) Monthly bank statements and reconciliations;

(b) Checkbook registers and bankbooks;

(c) Deposit receipts;

(d) Receipts for purchases over twenty-five dollars;

(e) A ledger showing deposits, withdrawals, and interest payments to each client; and

(f) A control journal for trust accounts.

(3) The service provider must keep the following documentation for cash and debit transactions:

(a) A detailed ledger signed by the staff who withdrew any of the client's money;

(b) A detailed accounting of the funds received on behalf of the client including:

(i) Cash received from writing checks over the purchase amount; and

(ii) A list of where the money was spent.

(c) Receipts for purchases over twenty-five dollars when service provider staff withdrew the money.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3580, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3590 Transferring client funds. (1) When the service provider manages a client's funds and the

client changes service providers, the previous service provider must transfer all of the client's funds, except funds necessary to pay unpaid bills, to the client or designee as soon as possible but no longer than thirty days.

(2) When transferring funds, the previous provider must:

(a) Have an agreement with the client regarding the amount of money to be withheld to pay bills;

(b) Inform the client's case manager about any agreement in subsection (2)(a) of this section;

(c) Give the client and the client's legal representative a written accounting of all known client funds;

(d) When applicable, give the new service provider a written accounting of all transferred client funds;

(e) Obtain a written receipt from the client and legal representative for all transferred funds; and

(f) When applicable, obtain the new service provider's written receipt for the transferred funds.

(3) When the client moves to another living arrangement without supported living services or the client's whereabouts are unknown, the service provider must transfer the client's funds within one hundred eighty days to:

(a) The client's legal representative;

(b) The department; or

(c) The requesting governmental entity.

(4) When the client dies, the service provider must transfer the client's funds within ninety days to:

(a) The client's legal representative;

(b) The requesting governmental entity; or

(c) The department if the client does not have a legal heir.

(5) Social Security Administration requirements for managing the client's Social Security income take precedence over these rules for transferring client funds if:

(a) The service provider is the client's representative payee; and

(b) The Social Security Administration requirement conflicts with these rules.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3590, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3600 Client loans. (1) The service provider may loan funds to a client from the service provider's funds and collect the debt from the client in installments.

(2) The client's service provider must not:

(a) Charge the client interest for any money loaned; or

(b) Borrow funds from the client.

(3) The provider must keep the following loan documentation for each loan:

(a) A loan agreement signed by the client or the client's legal representative;

(b) Amount of the loan;

(c) Payments on the loan balance; and

(d) The current balance owed.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3600, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3610 Client reimbursement. The service provider must pay the client the total amount involved when:

(1) The service provider or staff has stolen, misplaced, or mismanaged client funds; or

(2) Service charges are incurred on a trust account that the service provider manages for the client.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3610, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3620 Client payment. When the client performs work for the service provider, the service provider must pay the client:

(1) At least the current minimum wage; and

(2) According to state and federal requirements.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3620, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3630 Medication services—General.

(1) If the service provider is involved in assisting any client with medications, as identified in the client's individual support plan, the service provider must:

(a) Have systems in place to ensure that medications are given as ordered and in a manner that safeguards the client's health and safety;

(b) Ensure that each client receives their medication as prescribed, except as provided for in the medication refusal section or in the medication assistance section regarding altering medication; and

(c) Have a legible prescription label completed by a licensed pharmacy before providing medication assistance or medication administration to a client for prescribed medications.

(2) Group homes licensed as a boarding home or adult family home must meet the medication management requirements of chapter 388-78A or 388-76 WAC. For any difference in requirements the boarding home or adult family home medication rules take precedence over the medication rules of this chapter.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3630, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3640 Medication—Types of support.

The service provider must provide medication support as specified in the client's individual support plan. Types of client support include:

(1) Self-administration of medication;

(2) Medication assistance;

(3) Nurse delegated medication administration; and

(4) Medication administration by a practitioner.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3640, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3650 Medication—Self-administration.

If a client is assessed as independent in self-administration of medications the service provider must inform the client's case manager if they have a reason to suspect that the client is no longer safe to self-administer medications.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3650, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3660 Medication assistance. If the client is assessed as needing assistance with medication, the service provider may assist the client to take medications in any of the following ways:

(1) Communicating the prescriber's order to the client in such a manner that the client self-administers his/her medication properly;

(2) Reminding or coaching the client when it is time to take a medication;

(3) Opening the client's medication container;

(4) Handing the client the medication container;

(5) Placing the medication in the client's hand;

(6) Transferring medication from one container to another for the purpose of an individual dose (e.g., pouring a liquid medication from the container to a calibrated spoon or medication cup or using adaptive devices);

(7) Altering a medication by crushing or mixing:

(a) Only if the client is aware that the medication is being altered or added to food or beverage; and

(b) A pharmacist or other qualified practitioner has determined it is safe to alter medication; and

(c) It is documented on the prescription container or in the client's record.

(8) Guiding or assisting the client to apply or instill skin, nose, eye and ear preparations. Hand-over-hand administration is not allowed; and

(9) For group homes that have a boarding home or adult family home license, refer to chapter 388-78A or 388-76 WAC for additional tasks that may be allowed.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3660, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3670 Medication administration—Nurse delegation. If a client is assessed as requiring medication administration and the service provider is not a practitioner, the service provider must ensure the assistance is provided by a licensed health care professional or under nurse delegation as per chapters 246-840 WAC and 18.79 RCW.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3670, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3680 Medication administration. (1) If a service provider is a licensed health care professional, the licensed professional may administer the client's medication.

(2) Service providers may only administer medication under the order of a physician or a health care professional with prescriptive authority.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3680, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3690 Medication refusal. (1) When a client who is receiving medication support from the service provider chooses to not take his or her medications, the service provider must:

(a) Respect the client's right to choose not to take the medication(s) including psychoactive medication(s); and

(b) Document the time, date and medication the client did not take.

(2) The service provider must take the appropriate action, including notifying the prescriber or primary care practitioner, when the client chooses to not take his or her medications and the client refusal could cause harm to the client or others.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3690, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3700 Storage of medications. (1) The service provider must keep a client's medications so they are not readily available to other clients.

(2) The service provider must store medications:

(a) Under proper conditions for sanitation, temperature, moisture and ventilation, and separate from food or toxic chemicals; and

(b) In the original medication containers with pharmacist-prepared or manufacturer's label, or in medication organizers which are clearly labeled with the:

(i) Name of the client for whom the medication is prescribed;

(ii) Name of the medications; and

(iii) Dosage and frequency.

(3) Group homes must:

(a) Keep all medications in locked storage; and

(b) Use medication organizers only when filled by a pharmacist.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3700, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3710 Medication organizers. (1) Service providers may allow medication organizers maintained by the individual when the organizers are filled by:

(a) The client;

(b) A licensed pharmacist;

(c) An RN; or

(d) The client's legal representative or a family member.

(2) Service providers providing medication assistance or administration to a client must ensure that the medication organizers are labeled.

(3) The client, a pharmacist, an RN, or the client's legal representative or family member may label the medication organizer.

(4) When there is a change in medications by the prescriber, the individual filling the medication organizers must replace labels with required updated information immediately.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3710, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3720 Medications—Documentation. The service provider must maintain a written record of all medications administered to, assisted with, monitored, or refused by the client.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3720, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3730 Disposal of medications. (1) The service provider or his/her designee must properly dispose of all medications that are discontinued, out of date, or superseded by another.

(2) When disposing client medications the service provider must list the:

(a) Medication;

(b) Amount; and

(c) Date that it was disposed.

(3) Two people, one of whom may be the client, must verify the disposal by signature.

(4) For group homes that have a boarding home or adult family home license, refer to chapters 388-78A or 388-76 WAC for medication disposal requirements.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3730, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3740 Psychoactive medication assessment. If a client displays symptoms of mental illness and/or persistent challenging behavior, the service provider must:

- (1) Refer the client for a professional assessment;
- (2) Prior to the referral, prepare a psychiatric referral summary, including the frequency and severity of the symptoms or behaviors, and take or send this document to the treatment professional conducting the assessment;
- (3) Respect the client's preference to visit the treatment professional independently; and
- (4) If drugs are prescribed, have the prescribing professional assess the client at least annually to review the continued need for the medication(s) and possible dosage reduction.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3740, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3750 Psychoactive medication treatment plan. (1) If the assessing treatment professional recommends psychoactive medications, the prescribing professional or service provider must document this in the client's psychoactive medication treatment plan. The service provider must ensure the plan includes the following:

- (a) A description of the behaviors, symptoms or conditions for which the medication is prescribed and a mental health diagnosis, if available;
 - (b) The name, dosage, and frequency of the medication and subsequent changes in dosage must be documented in the person's medical record;
 - (c) The length of time considered sufficient to determine if the medication is effective;
 - (d) The behavioral criteria to determine whether the medication is effective and what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective; and
 - (e) The anticipated schedule of visits with the prescribing professional.
- (2) The service provider must make sure the treatment plan is updated when there is a change in psychoactive medication type, including intraclass changes.
- (3) The service provider must:
- (a) Review the name, purpose, potential side effects and any known potential drug interactions of the psychoactive medication(s) with the client and his/her legal representative and document the review in the client record; and
 - (b) Have available to staff and clients an information sheet for each psychoactive medication that is being used by each client served by the provider.
- (4) The service provider must assist the client in obtaining and taking the medication when:
- (a) The client's legal representative if any, is unavailable; and
 - (b) In the prescribing professional's opinion, medication is needed and no significant risks are associated with the use of the medication.

(5) If a client takes psychoactive medications to reduce challenging behaviors or to treat symptoms of a mental illness that are interfering with the client's ability to have positive life experiences and form and maintain relationships, the service provider must develop and implement a positive behavior support plan.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3750, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3760 Psychoactive medication monitoring. The service provider must:

- (1) Monitor the client to help determine if the medication is effective based on criteria identified in the psychoactive medication treatment plan; and
- (2) Report to the prescribing professional when:
 - (a) The medication does not appear to have the desired effects; and
 - (b) Any changes in client behavior or health that might be adverse side effects of the medication(s).

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3760, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3770 Psychoactive medications—Other. If psychoactive medications are used for diagnoses other than mental illness or persistent challenging behavior, the service provider must follow the general medication requirements in WAC 388-101-3630 through 388-101-3730.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3770, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3780 Confidentiality of client records.

- (1) The service provider must:
 - (a) Keep all client record information confidential;
 - (b) Ensure the department's right to have access to and copies of any records as requested or needed; and
 - (c) Provide access to and copies of client records to the client, or the client's legal representative upon their request.
- (2) The service provider must have an authorized release of information form for any transfer or inspection of records, other than those specified in subsection (1) of this section. The authorization form must:
 - (a) Be specific to the type of information about the transfer or inspection; and
 - (b) Be signed by the client or client's legal representative.
- (3) A signed release of information is valid for up to one year from the date of signature.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3780, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3790 Charging for searching and duplicating records. (1) The service provider:

- (a) Must not charge the department or the client for any searching or duplication of records requested or needed; and
 - (b) May charge the client's legal representative acting on behalf of the client for searching and duplication of records at a cost not to exceed twenty-five cents a page.
- (2) The service provider must not charge the client's legal representative acting on behalf of the client for search-

ing and duplication of records if the client is incapable of making the request.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3790, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3800 Retention of client records. (1)

While supporting a client, a service provider must keep all of the client's records for at least four years.

(2) After a client's participation with a service provider ends, the service provider must keep the client's records for at least six years.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3800, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3810 Contents of client records. (1)

Crisis diversion service providers are exempt from the client record requirements specified in this section.

(2) Service providers must keep, in each client's record, information including but not limited to the following:

- (a) Client's name, address, and Social Security number;
- (b) Name, address, and telephone number of the client's involved family members, guardian or legal representative;
- (c) Copies of legal guardianship papers, if provided;
- (d) Client health records, including:
 - (i) Name, address, and telephone number of the client's physician, dentist, mental health service provider, and any other current health care service provider;
 - (ii) Current health care service providers' instructions about health care needed, including appointment dates and date of next appointment if appropriate;
 - (iii) Written documentation that the health care service providers' instructions have been followed; and
 - (iv) Record of major health events and surgeries when known.
- (e) Copy of the client's most recent individual support plan;
- (f) Client's individual instruction and support plan including:
 - (i) Instruction and support activities for each client as a basis for review and evaluation of client's progress;
 - (ii) Semiannual review of the individual instruction and support plan;
 - (iii) Consultation with other service providers and other interested persons;
 - (iv) Individual instruction and support plan revisions and changes; and
 - (v) Other activities relevant to the client that the client wants included.
- (g) Progress notes and incident reports;
- (h) The client's financial records for funds managed by the service provider, including:
 - (i) Receipts, ledgers and records of the client's financial transactions; and
 - (ii) Client's related bankbooks, checkbooks, bank registers, tax records and bank statements.
- (i) Burial plans and wills.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3810, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3820 Client's property records. (1) Crisis diversion support service providers are exempt from the requirements in this section.

(2) The service provider must assist clients in maintaining current, written property records unless otherwise specified in the individual support plan. The record must consist of:

- (a) A list of personal possessions with a value of at least twenty-five dollars that the client owns when moving into the program;
- (b) A list of personal possessions with a value of seventy-five dollars or more per item after the client moves into the program;
- (c) Description and identifying numbers, if any, of the property;
- (d) The date the client purchased the items after moving into the program;
- (e) The date and reason for addition or removal from the record; and
- (f) The signature of the staff or client making the entry.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3820, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3830 Record entries. The service provider must ensure that all record entries are:

- (1) Documented in ink;
- (2) Written legibly at the time of or immediately following the occurrence of the event recorded; and
- (3) Signed and dated by the person making the entry.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3830, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3840 Positive behavior support. Positive behavior support means a recognized approach to supporting clients with challenging behaviors. Positive behavior support focuses on changing the client's environment, skills, and other factors that contribute to the client's challenging behavior(s). Positive behavior support uses a functional assessment to help build respectful plans for clients with challenging behavior(s).

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3840, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3850 Functional assessment. (1) The service provider must conduct and document a functional assessment before developing and implementing a client's positive behavior support plan.

(2) The service provider must start the functional assessment when the client begins to engage in challenging behaviors that interfere with the client's ability to have positive life experiences and form and maintain relationships.

(3) The service provider must ensure that a client's written functional assessment addresses:

- (a) A description of the client and pertinent history;
- (b) The client's overall quality of life;
- (c) The behaviors that are considered challenging and/or are of concern;
- (d) The factors or events which increase the likelihood of challenging behaviors;
- (e) When and where the challenging behavior(s) occurs most frequently;

(f) The factors or events which increase the likelihood of appropriate behavior;

(g) An analysis and assessment of the possible functions or purpose the challenging behavior(s) serve for the client including what he or she obtains or avoids by engaging in the behavior(s); and

(h) A concluding summary of the functions or purpose that each challenging behavior serves for the client.

(4) The service provider must include the following sections in the format of each client's written functional assessment:

- (a) Description and pertinent history;
- (b) Definition of challenging behaviors;
- (c) Data analysis/assessment procedures; and
- (d) Summary statement(s).

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3850, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3860 Positive behavior support plan.

(1) The service provider must develop, train to, and implement a written individualized positive behavior support plan for each client when:

(a) The client takes psychoactive medications to reduce challenging behavior or treat a mental illness currently interfering with the client's ability to have positive life experiences and form and maintain personal relationships; or

(b) Restrictive procedures, including physical restraints, identified in the residential services contract are planned or used.

(2) The service provider must:

(a) Base each client's positive behavior support plan on the functional assessment required in WAC 388-101-3850; and

(b) Complete and implement the client's positive behavior support plan within ninety days of identifying the client's symptoms and challenging behavior.

(3) The service provider must develop and implement a positive behavior support plan that is consistent with the client's cross system crisis plan, if any.

(4) The service provider must include the following sections in the format of each client's written positive behavior support plan:

- (a) Prevention strategies;
- (b) Teaching and training supports;
- (c) Strategies for responding to challenging behaviors;

and

(d) Data collection and monitoring methods.

(5) If data indicates that progress is not occurring after a reasonable time, but not longer than six months, the service provider must:

(a) Evaluate the positive behavior support plan and the data collected;

(b) Conduct a new functional assessment when necessary; and

(c) Develop and implement revisions as needed.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3860, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3870 Client protection. While the functional assessment and positive behavior support plan are being developed, the service provider must:

(1) Protect the client and others; and

(2) Document in the client's record how the protection is being done.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3870, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3880 Group home providers. (1)

When considering restrictive procedures, group home providers licensed as boarding homes must comply with all requirements in chapter 388-78A WAC regarding restraints.

(2) When considering restrictive procedures, group home providers licensed as adult family homes must comply with all requirements in chapter 388-76 WAC regarding restraints.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3880, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3890 Restrictive procedures. (1) The service provider may:

(a) Only use restrictive procedures for the purpose of protecting the client, others, or property; and

(b) Not use restrictive procedures for the purpose of changing behavior in situations where no need for protection is present.

(2) The service provider must have documentation on the proposed intervention strategy before implementing restrictive procedures including:

(a) A description of the behavior(s) that the restrictive procedures address;

(b) A functional assessment of the challenging behavior(s);

(c) The positive behavior support strategies that will be used;

(d) A description of the restrictive procedure that will be used including:

(i) When and how it will be used; and

(ii) Criteria for termination of the procedure; and

(e) A plan to document the use of the procedure and its effect.

(3) The service provider must terminate implementation of the restrictive procedures as soon as the need for protection is over.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3890, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3900 Restrictive procedures approval. (1) The service provider must have documentation of the proposed intervention strategy that:

(a) Lists the risks of the challenging behavior(s);

(b) Lists the risks of the proposed restrictive procedure(s);

(c) Explains why less restrictive procedures are not recommended;

(d) Indicates nonrestrictive alternatives to the recommendation that have been tried but were unsuccessful; and

(e) Includes space for the client and/or the client's legal representative to write comments and opinions regarding the plan and the date of those comments.

(2) The service provider must consult with the division of developmental disabilities if:

- (a) The client and/or the client's legal representative disagree with parts of the proposed restrictive procedure; and
- (b) An agreement cannot be reached.
- (3) Before the service provider implements restrictive procedures they must be approved in writing by:
 - (a) The service provider's administrator; or
 - (b) Someone designated by the service provider to have approval authority; and
- (c) Someone designated by the division of developmental disabilities, when required by the residential services contract.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3900, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3910 Physical intervention systems.

Service providers who are using physical interventions with clients must have a physical intervention techniques system that includes at least the following:

- (1) Discussion of the need for positive behavior support;
- (2) Communication styles that help the client to calm down and resolve problems;
- (3) Techniques to prevent escalation of behavior before it reaches the stage of physical assault;
- (4) Techniques for staff to use in response to clients and their own fear, anger, aggression, or other negative feelings;
- (5) Cautions that physical intervention technique(s) may not be changed except as needed for individual disabilities, medical, health, and safety issues. A healthcare professional and a program trainer must approve all modifications;
- (6) Evaluation of the safety of the physical environment;
- (7) Issues of respect and dignity of the client;
- (8) Use of the least restrictive physical interventions depending upon the situation;
- (9) Identification of division of developmental disabilities approved and prohibited physical intervention techniques;
- (10) The need to release clients from physical restraint as soon as possible;
- (11) Instruction on how to support physical interventions as an observer, recognizing signs of:
 - (a) Distress by the client; and
 - (b) Fatigue by the staff; and
- (12) Discussion of the importance of complete and accurate documentation.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3910, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3920 Physical interventions. (1) The service provider must use the least restrictive intervention needed to protect each client, others, and property.

(2) The service provider may only use physical interventions with a client when positive or less restrictive techniques have been tried and determined to be insufficient to:

- (a) Protect the client;
- (b) Protect others; or
- (c) Prevent property damage.
- (3) The service provider must:
 - (a) Terminate the intervention for the client as soon as the need for protection is over; and
 - (b) Only use restrictive physical interventions for the client as part of a positive behavior support plan except:

- (i) In an emergency when a client's behavior presents an immediate risk to the health and safety of the client or others, or a threat to property; or
- (ii) When an unknown, unpredicted response from a client jeopardizes the client's or others safety.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3920, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3930 Restrictive physical interventions. Prior to implementing restrictive physical interventions with a client, the provider must:

- (1) Provide documentation to the division of developmental disabilities regarding the proposed intervention;
- (2) Involve the client and the client's legal representative in discussion regarding the need for physical intervention;
- (3) Determine the kind of notification the client's legal representative wants to receive when physical interventions are used; and
- (4) Comply with the requirements defined under WAC 388-101-3890.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3930, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3940 Physical intervention training.

(1) Before using physical interventions with a client, the provider must train all staff who will be implementing those interventions in:

- (a) The use of physical interventions;
- (b) Crisis prevention techniques; and
- (c) Positive behavior support.
- (2) Each staff designated to supervise or observe restraint use must be trained in:
 - (a) The observation and supervision of physical restraints; and
 - (b) The recognition of potential risks or negative outcomes related to the use of physical restraints.
- (3) The service provider must ensure that staff receiving physical intervention techniques training:
 - (a) Complete the course of instruction;
 - (b) Demonstrate competency before being authorized to use the techniques with clients; and
 - (c) Review deescalation and physical intervention techniques annually.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3940, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3950 Mechanical and chemical restraints. (1) The service provider must protect each client's right to be free from mechanical and chemical restraints and involuntary seclusion.

(2) The service provider must use the least restrictive alternatives needed to protect the client, others, or property.

(3) If needed, mechanical restraints may only be used for needed medical or dental treatment and only under the direction of a licensed physician or dentist.

(4) Restraints used as allowed by subsection (3) of this section must be justified and documented in the client's record.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3950, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3960 Monitoring physical and mechanical restraints. (1) The service provider must ensure that any client who is being physically or mechanically restrained is continuously observed to ensure that risks to the client's health and safety are minimized.

(2) The service provider must keep documentation that includes:

- (a) A description of events immediately preceding the client's behavior which led to the use of the restraint;
- (b) The type of restraint used;
- (c) Length of time the client was restrained;
- (d) The client's reaction to the restraint;
- (e) Staff that were involved; and
- (f) Injuries sustained by anyone during the intervention.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3960, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3970 Community protection—Approval. In order to provide support to community protection clients, the community protection service provider must, in addition to the other requirements in this chapter:

- (1) Be approved by the division of developmental disabilities to serve community protection clients;
- (2) Have security precautions reasonably available to enhance protection of neighbors, children, vulnerable adults, animals, and others;
- (3) Have for each client an integrated treatment plan with goals, objectives, and therapeutic interventions to assist the client to avoid offending or reoffending; and
- (4) Collaborate and coordinate between division of developmental disabilities staff, the treatment team, and community agencies and members.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3970, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3980 Community protection—Policies and procedures. A community protection service provider must, in addition to other policy and procedure requirements listed in this chapter, develop, train to, and implement the following procedures:

- (1) Client security and supervision;
- (2) Use of a chaperone agreement that describes who will supervise the client when the client is not under the direct supervision of the community protection service provider;
- (3) Compliance with state laws requiring sex offender registration with law enforcement;
- (4) Reporting to the division of developmental disabilities the client's refusal to comply with the treatment plan; and
- (5) Reporting to the division of developmental disabilities and law enforcement client actions that violate the law or a court order.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3980, filed 12/21/07, effective 2/1/08.]

WAC 388-101-3990 Community protection—Treatment team meetings. The community protection service provider must participate in treatment team meetings quarterly or more frequently as needed.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-3990, filed 12/21/07, effective 2/1/08.]

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WAC 388-101-4000 Community protection—Staff training. In addition to the staff training requirements in this chapter and the residential services contract, the community protection service provider must ensure that community protection program staff receive training specific to:

- (1) Community protection within ninety calendar days of working with a community protection client; and
- (2) The needs, supports, and services for clients to whom they are assigned.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4000, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4010 Community protection—Written individual plan. (1) The community protection service provider must develop and implement a client's written individual plan as required in the residential services contract and that is based on:

- (a) A qualified professional's risk assessment of emotional and behavioral issues related to community protection risks; or
- (b) A written risk assessment and treatment recommendations by:
 - (i) A sexual offender treatment provider or sexual offender treatment provider affiliate if the client has a sexual offense history; or
 - (ii) A licensed psychologist or psychiatrist with specialized training in the treatment of or three or more years' experience treating violent or aggressive behavior when the person being assessed has demonstrated violent, dangerous, or aggressive behavior.

(2) In addition to the requirements in WAC 388-101-3460 through 388-101-3510, the community protection service provider must include the following in the client's written individual plan:

- (a) Intervention strategies and techniques related to community protection risks;
 - (b) Restrictions and measures, including security precautions; and
 - (c) A therapist's approval of the written individual plan.
- (3) For community protection clients with a history of sexual offending, the assessment by a certified sexual offender treatment provider or sexual offender treatment provider affiliate may serve as the functional assessment and treatment recommendations related to the sexual behaviors.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4010, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4020 Community protection—Client records. In addition to all other client record requirements in this chapter community protection service providers must include the following in the client's record:

- (1) Psychosexual and/or psychological evaluations and risk assessments;
- (2) Plans and assessments including:
 - (a) The written individual plan;
 - (b) The functional assessment;
 - (c) The positive behavior support plan; and
 - (d) A therapist approved treatment plan.
- (3) The client's sex offender registration with law enforcement authorities when required by law;

(4) Notice to the division of developmental disabilities of the client's sex offender registration; and

(5) Agreements, requirements, and plans, including the chaperone agreement, with individuals who support the client.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4020, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4030 Community protection—Client transportation. In addition to the other client transportation requirements defined in this chapter, community protection service providers must provide or ensure supervised transportation as needed, including but not necessarily limited to, medical emergencies, appointments, to and from the day program site, and community activities.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4030, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4040 Community protection—Program residential location. Before securing and using a residence to provide support to the community protection program client, the community protection service provider must:

- (1) Conduct and document site checks of the proposed residence at different days and times of the week;
- (2) Consider the client's specific offense patterns;
- (3) Determine appropriate and necessary restrictive procedures, including security precautions; and
- (4) Obtain written approval for the residential site from the division of developmental disabilities.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4040, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4050 Community protection—Reducing a client's restrictions. The community protection service provider must participate in any treatment team meetings held to review and consider a reduction in client restrictions.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4050, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4060 Community protection—Leaving the program against treatment team advice. (1) The community protection service provider must immediately notify the division of developmental disabilities when the client leaves the community protection program against treatment team advice; and

- (2) Document the client's departure in the client's record.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4060, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4070 Crisis diversion—Access to services. The crisis diversion services provider must:

- (1) Be approved by the department to provide crisis diversion services; and
- (2) Make crisis diversion services available to clients twenty-four hours per day.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4070, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4080 Crisis diversion bed services—Location. The crisis diversion bed services provider must:

(1) Provide those services in a residence that is maintained by the crisis diversion bed services provider;

(2) Provide a private, furnished bedroom for each crisis diversion client; and

- (3) Support only one client in each residence.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4080, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4090 Crisis diversion bed services—Services and activities. The crisis diversion bed services provider must provide the following services and activities:

(1) Support staff, twenty-four hour per day, seven days a week, to meet the client's needs as identified in the client's assessment;

(2) Access to the instruction and support services identified in the client's individual support plan;

(3) Three meals per day plus snacks;

(4) The following items at no cost to the client:

(a) Toiletries and personal care items;

(b) Bedding and towels;

(c) Access to laundry facilities; and

(d) Access to local telephone calls.

(5) Therapeutic interventions aimed at improving the client's functioning;

(6) Medication monitoring as needed;

(7) Transportation to and from the crisis diversion bed location and other necessary appointments or services;

(8) Referral to health care services as needed;

(9) Supports for performing personal hygiene routines and activities of daily living if needed by the client; and

(10) An accessible site for clients with physical disabilities.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4090, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4100 Crisis diversion bed services—Treatment plan. (1) Crisis diversion bed services providers must develop a crisis services treatment plan within forty-eight hours of the client's placement.

(2) The treatment plan must include:

(a) The supports and services that must be provided; and

(b) Client discharge goals.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4100, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4110 Crisis diversion bed and support service providers—Client records. (1) Crisis diversion bed and support service providers must keep the following information in client records:

(a) Client's name, address, and Social Security number;

(b) Name, address, and telephone number of the client's relative or legal representative; and

(c) Progress notes and incident reports on clients.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4110, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4120 Crisis diversion bed services—Client records. (1) Crisis diversion bed services providers must maintain a record for each client admitted to the crisis diversion bed.

(2) The client record must include the following information when available:

- (a) Basic demographic information;
- (b) Referral process and intake information;
- (c) Medication records;
- (d) Psychiatric records;
- (e) Crisis diversion bed services provider notes;
- (f) The crisis services treatment plan;
- (g) Cross systems crisis plan;
- (h) Disposition at the client's discharge;
- (i) Dates of admission and discharge;
- (j) Incident reports;
- (k) Copies of legal representative and guardianship papers;
- (l) Health records including the name, address, and telephone number of the client's:
 - (i) Physician;
 - (ii) Dentist;
 - (iii) Mental health service provider; and
 - (iv) Any other health care service providers.
- (m) Health care service providers' instructions, if any, about health care tasks and date of next appointment;
- (n) Written documentation that the health care service providers' instructions have been followed; and
- (o) A record of known major health events, including surgeries.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4120, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4130 Crisis diversion support services—Location. The crisis diversion support services provider must provide those services in the client's own home.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4130, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4140 Crisis diversion support services—Services and activities. The crisis diversion support services provider must provide the following services and activities:

- (1) Therapeutic interventions to help stabilize the client's behavioral symptoms;
- (2) Assistance with referral to mental health services if needed; and
- (3) Technical assistance to the client's caregivers on support strategies.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4140, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4150 Mandated reporting to the department. Service providers, administrators, owners, and staff:

- (1) Are mandated reporters and must meet the requirements of chapter 74.34 RCW;
- (2) Must make mandated reports to the department's centralized toll free complaint telephone number or fax number immediately when:
 - (a) There is reasonable cause to believe that a vulnerable adult, as defined in chapter 74.34 RCW, has been abandoned, abused, neglected, or financially exploited; or

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(b) There is a reason to suspect physical or sexual assault.

(3) Must also make written and oral reports to the department as specified in the provider's residential services contract;

(4) Must protect the alleged victim and others from further abuse, neglect, abandonment, and financial exploitation; and

(5) May have their certification and/or contract terminated if they fail to report such incidents.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4150, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4160 Mandated reporting to law enforcement. Service providers, administrators, owners, and staff must immediately report to the appropriate law enforcement agency if there is reason to suspect that any of the following has occurred:

(1) Sexual assault: Any alleged or suspected sexual assault;

(2) Physical assault (nonclient to client): Any suspected physical assault as well as any act that causes fear of imminent harm; and

(3) Physical assault (client to client): Any suspected physical assault that causes bodily injury requiring more than first aid, or in the event of:

(a) Injuries that appear on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

(b) Fractures;

(c) Choking attempts;

(d) Patterns of physical assault between the same vulnerable adults or involving the same vulnerable adults;

(e) A reasonable cause to believe that an act has caused fear of imminent harm; and

(f) Any incident, regardless of injury, if requested by the client, his/her legal representative, or family member.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4160, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4170 Mandating reporting policies and procedures. (1) The service provider must develop, train on and implement written policies and procedures for:

(a) Immediately reporting mandated reporting incidents to:

(i) The department and law enforcement;

(ii) Appropriate persons within the service provider's agency as designated by the service provider; and

(iii) The alleged victim's legal representative.

(b) Protecting clients;

(c) Preserving evidence when necessary; and

(d) Initiating an outside review or investigation.

(2) The service provider must not have or implement any policies or procedures that interfere with a mandated reporter's obligation to report.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4170, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4190 Provisional certification. (1) The department may impose a provisional certification, not to

exceed one hundred eighty days, if any service provider does not comply with requirements of this chapter, other applicable laws and rules, or the residential services contract.

(2) At the end of provisional certification the department may:

(a) Approve the service provider for regular certification if the service provider has complied with certification requirements; or

(b) Revoke the service provider's certification and terminate the residential services contract if the service provider has not complied with all certification requirements.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4190, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4200 Decertification. The department may revoke any service provider's certification at any time for noncompliance with the requirements of this chapter, the department's residential services contract, the requirements of chapter 74.34 RCW or other relevant federal, state and local laws, requirements or ordinances.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4200, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4210 Community protection program—Circumstances resulting in enforcement remedies. (1) This section applies only to service providers providing services to community protection clients.

(2) The department is authorized to impose the enforcement remedies described in chapter 71A.12 RCW when the service provider has:

(a) Failed or refused to comply with the requirements of chapter 71A.12 RCW and the rules adopted under the chapter;

(b) Failed or refused to comply with the certification process;

(c) Prevented or interfered with the department's certification evaluation or complaint investigation by the department;

(d) Failed to comply with any applicable requirements regarding vulnerable adults under chapter 74.34 RCW; or

(e) Knowingly, or with reason to know, made a false statement of material fact related to certification or contracting with the department, or in any matter under investigation by the department.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4210, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4220 Community protection program—Authorized enforcement remedies. (1) This section applies only to service providers providing services to community protection clients.

(2) Whenever circumstances in WAC 388-101-4210 are present the department may impose any enforcement remedies authorized by chapter 71A.12 RCW and any rules adopted under it. The department may:

(a) Decertify or refuse to renew the certification of a service provider;

(b) Impose conditions on a service provider's certification status;

(c) Suspend department referrals to the service provider;

(d) Require a service provider to implement a plan of correction developed by the department and to cooperate with subsequent monitoring of the service provider's progress;

(e) Impose civil penalties of not more than one hundred fifty dollars per day per violation in the event a service provider fails to implement the plan of correction developed by the department or fails to cooperate with any subsequent monitoring; and

(f) Impose a separate violation each day during which the same or similar action or inaction occurs.

(2) The provisions of chapter 34.05 RCW apply to enforcement actions under this section. Except for the imposition of civil penalties, the effective date of enforcement actions will not be delayed or suspended pending any hearing or informal review.

(3) The enforcement actions and penalties authorized in this section are not exclusive or exhaustive and nothing in this section prohibits the department from taking any action authorized in statute or rule or under the terms of a contract with the service provider.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4220, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4230 Community protection program—Considerations for imposing remedies. (1) This section applies only to service providers providing services to community protection clients.

(2) When determining the appropriate enforcement action under WAC 388-101-4220, the department will select actions in proportion to the seriousness of the harm or threat of harm to clients being served by the service provider.

(3) The department may take enforcement actions that are more severe for violations that are uncorrected, repeated, or pervasive or which present a serious threat of harm to the health, safety or welfare of clients served by the service provider.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4230, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4240 Informal dispute resolution. (1) When a service provider disagrees with the department's finding of a violation or certification action under this chapter, the service provider may request an informal dispute resolution meeting with the department.

(2) The service provider must make a written request to the department for an informal dispute resolution meeting within ten working days of receipt of the written notice of the department's final report of findings and/or certification action.

(3) The service provider must submit a written statement identifying the challenged action, and include specifically the issues and regulations involved.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4240, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4250 Administrative review. (1) A service provider may request an administrative review of a certification action within twenty-eight days of receipt of the written notice of the department's certification action.

(2) The service provider must make the request in writing and must:

- (a) Sign the request;
- (b) Identify the challenged decision and the date it was made;
- (c) State specifically the issues and regulations involved and the grounds for the disagreement; and
- (d) Include with the request copies of any supporting documentation for the service provider's position.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4250, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4260 Appeal rights. (1) A service provider:

- (a) May contest a decision made by the department pursuant to chapter 71A.12 RCW and according to the provisions of chapters 34.05 RCW and 388-02 WAC;
- (b) Must file any request for a hearing with the office of administrative hearings at the mailing address specified in the notice of imposition of an enforcement remedy; and
- (c) Must make the request within twenty-eight days of receipt of the written notice of the department's certification action.

(2) Certification actions are effective immediately upon notice and will continue pending any hearing.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4260, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4265 Investigation of reports. (1) The department may investigate allegations of abandonment, abuse, neglect, or financial exploitation of a client.

(2) The department investigation may include an investigation of allegations about one or more of the following:

- (a) A service provider;
- (b) Anyone associated with a service provider; or
- (c) A client receiving services under this chapter.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4265, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4270 Notice of preliminary finding.

(1) The department will notify the alleged perpetrator in writing within ten working days of making a preliminary finding of abandonment, abuse, neglect or financial exploitation of a client. The written notice:

- (a) Will not include the identities of the alleged victim, reporter and witnesses; and
- (b) Will include the necessary information for the alleged perpetrator to ask for an administrative hearing to challenge the preliminary finding.

(2) The department must make a reasonable, good faith effort to determine the last known address of the alleged perpetrator.

(3) The department will serve notice of the preliminary finding as provided in chapter 388-02 WAC.

(4) The department may extend the time frame for written notification beyond ten working days for good cause.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4270, filed 12/21/07, effective 2/1/08.]

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WAC 388-101-4280 Reporting preliminary findings.

(1) In a manner consistent with confidentiality requirements concerning the client, witnesses, and reporter, the department may provide notification of a preliminary finding to:

- (a) Other divisions within the department;
- (b) The agency or program identified under RCW 74.34.068 with which the alleged perpetrator is associated as an employee, volunteer or contractor;
- (c) The employer or program that is currently associated with the individual alleged to have abandoned, abused, neglected, or financially exploited a client, if known;
- (d) Law enforcement; and
- (e) Other investigative authorities consistent with chapter 74.34 RCW.

(2) The notification will identify the finding as a preliminary finding.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4280, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4290 Disputing a preliminary finding.

(1) An alleged perpetrator of abandonment, abuse, neglect, or financial exploitation of a client may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the alleged perpetrator's written request for a hearing within thirty calendar days of the date written on the notice of the preliminary finding.

(4) The written request for a hearing must include:

- (a) The full legal name, current address and phone number of the alleged perpetrator;
- (b) A brief explanation of why the alleged perpetrator disagrees with the preliminary finding;
- (c) A description of any assistance needed in the administrative appeal process by the alleged perpetrator, including a foreign language or sign language interpreter or any reasonable accommodation for a disability; and
- (d) The alleged perpetrator's signature.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4290, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4300 Disclosure of investigative and finding information. (1) Confidential information about clients and mandated reporters received from the department may only be used by the alleged perpetrator to challenge preliminary findings through the appeal process.

(2) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the client will be redacted from documents unless release of that information is consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4300, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4310 Hearing procedures to dispute a preliminary finding. (1) Chapters 34.05 and 74.34 RCW, chapter 388-02 WAC, and the provisions of this chapter govern any appeal regarding a preliminary finding. In the event

of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter shall prevail.

(2) The administrative law judge shall determine whether a preponderance of the evidence supports the preliminary finding that the alleged perpetrator abandoned, abused, neglected, or financially exploited a vulnerable adult, and shall issue a preliminary order.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4310, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4320 Appeal of the administrative law judge's preliminary order on a finding. (1) If the alleged perpetrator or the department disagrees with the administrative law judge's decision, either party may challenge this decision by filing a petition for review with the department's board of appeals under chapters 34.05 RCW and 388-02 WAC.

(2) If the department appeals the administrative law judge's decision, the department will not modify the finding in the department's records until a final hearing decision is issued.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4320, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4330 Finalizing a preliminary finding.

(1) A preliminary finding becomes a final finding when:

(a) The department gives the alleged perpetrator notice of the preliminary finding pursuant to WAC 388-101-4270 and the alleged perpetrator does not request an administrative hearing;

(b) The administrative law judge:

(i) Dismisses the hearing following withdrawal of the appeal or default; or

(ii) Issues a preliminary order upholding the finding and the alleged perpetrator fails to appeal the preliminary order to the department's board of appeals; or

(c) The board of appeals issues a final order upholding the finding.

(2) The final finding is permanent and will only be removed from the department's records if:

(a) It is rescinded following judicial review; or

(b) The department may decide to remove the single finding of neglect from its records based upon a written petition by the alleged perpetrator provided that no further findings have occurred, and at least one calendar year has passed since the finding was finalized and recorded.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4330, filed 12/21/07, effective 2/1/08.]

WAC 388-101-4340 Reporting final findings. (1) The department will report a final finding of abandonment, abuse, neglect and financial exploitation within ten working days to the following:

(a) The perpetrator;

(b) The service provider that was associated with the perpetrator during the time of the incident;

(c) The service provider that is currently associated with the perpetrator, if known;

(d) The appropriate licensing, contracting, or certification authority; and

(e) The federal or state department or agency list of individuals found to have abandoned, abused, neglected, or financially exploited a vulnerable adult.

(2) The findings may be disclosed to the public upon request subject to applicable public disclosure laws.

[Statutory Authority: Chapter 71A.12 RCW. 08-02-022, § 388-101-4340, filed 12/21/07, effective 2/1/08.]

Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES

WAC

388-105-0050 Supplementation—General requirements.
388-105-0055 Supplementation—Unit or bedroom.

WAC 388-105-0050 Supplementation—General requirements.

(1) Supplementation of the Medicaid daily payment rate is an additional payment requested from a Medicaid recipient or a third-party payer by an adult family home (AFH) contractor or a licensed boarding home contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living (AL) services.

(2) The AFH, ARC, EARC, or AL contractor may not request supplemental payment of a Medicaid recipient's daily rate for services or items that are covered in the daily rate, and the contractor is required to provide:

(a) Under licensing chapters 388-76 or [388-]78A WAC and chapter 388-110 WAC; and/or

(b) In accordance with his or her contract with the department.

(3) Before a contractor may request supplemental payments, the contractor must have a supplemental payment policy that has been given to all applicants for admittance and current residents. In the policy, the contractor must inform the applicant for admittance or current resident that:

(a) The department Medicaid payment plus any client participation assigned by the department is payment in full for the services, items, activities, room and board required by the resident's negotiated service plan per chapter 388-78A WAC or the negotiated care plan per chapter 388-76 WAC and its contract with the department; and

(b) Additional payments requested by the contractor are for services, items, activities, room and board not covered by the Medicaid per diem rate.

(4) For services, items and activities, the supplementation policy must comply with RCW 70.129.030(4).

(5) For units or bedrooms for which the contractor may request supplemental payments, the contractor must include in the supplemental payment policy the:

(a) Units and/or bedrooms for which the contractor may request supplementation;

(b) Action the contractor will take when a private pay resident converts to Medicaid and the resident or a third party is unwilling or unable to pay a supplemental payment in order for the resident to remain in his or her unit or bedroom. When the only units or bedrooms available are those for which the contractor charges a supplemental payment, the contractor's policy may require the Medicaid resident to move from the facility. However, the contractor must give the Medicaid res-

ident thirty days notice before requiring the Medicaid resident to move.

(6) For the Medicaid resident for whom the contractor receives supplemental payments, the contractor must indicate in the resident's record the:

- (a) Unit or bedroom for which the contractor is receiving a supplemental payment;
- (b) Services, items, or activities for which the contractor is receiving supplemental payments;
- (c) Who is making the supplemental payments;
- (d) Amount of the supplemental payments; and
- (e) Private pay charge for the unit or bedroom for which the contractor is receiving a supplemental payment.

(7) When the contractor receives supplemental payment for a unit or bedroom, the contractor must notify the Medicaid resident's case manager of the supplemental payment.

[Statutory Authority: RCW 74.39A.901. 07-04-042, § 388-105-0050, filed 1/30/07, effective 3/2/07.]

WAC 388-105-0055 Supplementation—Unit or bedroom. When the AFH, ARC, EARC, or AL contractor only has one type of unit or all private bedrooms, the contractor may not request supplementation from the Medicaid applicant/resident or a third party, unless the unit or private bedroom has an amenity that some or all of the other units or private bedrooms lack e.g., a bathroom in private bedroom, a view unit, etc.

[Statutory Authority: RCW 74.39A.901. 07-04-042, § 388-105-0055, filed 1/30/07, effective 3/2/07.]

**Chapter 388-106 WAC
LONG-TERM CARE SERVICES**

WAC

| | |
|--------------|--|
| 388-106-0060 | Who must perform the assessment? |
| 388-106-0070 | Will I be assessed in CARE? |
| 388-106-0095 | How does the CARE tool measure clinical complexity? |
| 388-106-0213 | How are my needs assessed if I am a child applying for MPC services? |
| 388-106-0225 | How do I pay for MPC? |
| 388-106-0300 | What services may I receive under community options program entry system (COPEs) when I live in my own home? |
| 388-106-0500 | What services may I receive under medically needy in-home waiver (MNIW)? |

WAC 388-106-0060 Who must perform the assessment? The assessment must be performed by the department. Beginning January 1, 2008, individuals requesting personal care services will be assessed as described in the following chart:

| Age of person requesting an assessment for personal care services | Has the person been determined to meet DDD eligibility requirements? | Who will perform the assessment for personal care services? | What assessment will be used? |
|---|--|---|---|
| Under eighteen years of age | Yes | DDD | CARE/DDD Assessment per chapter 388-828 WAC |
| Under eighteen years of age | No | DDD | CARE/LTC Assessment per chapter 388-106 WAC |

| Age of person requesting an assessment for personal care services | Has the person been determined to meet DDD eligibility requirements? | Who will perform the assessment for personal care services? | What assessment will be used? |
|---|--|---|---|
| Eighteen years of age and older | Yes | DDD | CARE/DDD Assessment per chapter 388-828 WAC |
| Eighteen years of age and older | No | HCS | CARE/LTC Assessment per chapter 388-106 WAC |

[Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-106-0060, filed 11/28/07, effective 1/1/08; 05-11-082, § 388-106-0060, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0070 Will I be assessed in CARE? You will be assessed in CARE if you are applying for or receiving DDD services, COPEs, MNIW, MNRW, MPC, chore, respite, adult day health, GAU-funded residential care, PACE, private duty nursing, New Freedom or long-term care services within the MMIP or WMIP programs.

If you are under the age of eighteen and within thirty calendar days of your next birthday, CARE determines your assessment age to be that of your next birthday.

[Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-106-0070, filed 11/28/07, effective 1/1/08; 07-10-024, § 388-106-0070, filed 4/23/07, effective 6/1/07; 05-11-082, § 388-106-0070, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0095 How does the CARE tool measure clinical complexity? The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

| Condition | AND an ADL Score of |
|---|---------------------|
| ALS (Lou Gehrig's Disease) | >14 |
| Aphasia (expressive and/or receptive) | >=2 |
| Cerebral Palsy | >14 |
| Diabetes Mellitus (insulin dependent) | >14 |
| Diabetes Mellitus (noninsulin dependent) | >14 |
| Emphysema & Shortness of Breath (at rest or exertion) or dizziness/vertigo | >10 |
| COPD & Shortness of Breath (at rest or exertion) or dizziness/vertigo | >10 |
| Explicit terminal prognosis | >14 |
| Hemiplegia | >14 |
| Multiple Sclerosis | >14 |
| Parkinson Disease | >14 |
| Pathological bone fracture | >14 |
| Quadriplegia | >14 |
| Rheumatoid Arthritis | >14 |
| You have one or more of the following skin problems: <ul style="list-style-type: none"> ■ Pressure ulcers, with areas of persistent skin redness; ■ Pressure ulcers with partial loss of skin layers; ■ Pressure ulcers, with a full thickness lost; ■ Skin desensitized to pain/pressure; ■ Open lesions; and/or ■ Stasis ulcers. AND You require one of the following types of assistance: <ul style="list-style-type: none"> ■ Ulcer care; ■ Pressure relieving device; ■ Turning/reposition program; ■ Application of dressing; or ■ Wound/skin care. | >=2 |

| Condition | AND an ADL Score of |
|---|---------------------|
| You have a burn(s) and you need one of the following: <ul style="list-style-type: none"> ■ Application of dressing; or ■ Wound/skin care | >=2 |
| You have one or more of the following problems: <ul style="list-style-type: none"> ■ You are frequently incontinent (bladder); ■ You are incontinent all or most of the time (bladder); ■ You are frequently incontinent (bowel); or ■ You are incontinent all or most of the time (bowel). <p style="text-align: center;">AND</p> One of the following applies: <ul style="list-style-type: none"> ■ The status of your individual management of bowel bladder supplies is "Uses, has leakage, needs assistance"; ■ The status of your individual management of bowel bladder supplies is "Does not use, has leakage"; or ■ You use any scheduled toileting plan. | >10 |
| You have a current swallowing problem, and you are not independent in eating. | >10 |
| You have Edema. | >14 |
| You have Pain daily. | >14 |
| You need and receive a Bowel program. | >10 |
| You need Dialysis. | >10 |
| You require IV nutritional support or tube feedings; and Your total calories received per IV or tube was at least 25%; and Your fluid intake is greater than 2 cups. | >=2 |
| You need Hospice care. | >14 |
| You need Injections. | >14 |
| You need Intravenous medications. | >10 |

| Condition | AND an ADL Score of |
|---|---------------------|
| You need management of IV lines. | >10 |
| You need Ostomy care. | >=2 |
| You need Oxygen therapy. | >10 |
| You need Radiation. | >10 |
| You need and receive Passive range of motion. | >10 |
| You need and receive Walking training. | >10 |
| You need Suction treatment. | >=2 |
| You need Tracheostomy care. | >10 |
| You need a Ventilator/respirator | >10 |
| You are <18 and you have pain related to your disability and you complain of pain or show evidence of pain daily. (If you are under eighteen and do not have pain related to your disability, you may be placed in the clinically complex classification based on other factors above.) | >14 |
| Key: < means less than. > means greater than. >= means greater than or equal to. | |

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-10-024, § 388-106-0095, filed 4/23/07, effective 6/1/07; 05-11-082, § 388-106-0095, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0213 How are my needs assessed if I am a child applying for MPC services? If you are a child applying for MPC services, the department will complete a CARE assessment and:

- (1) Consider and document the role of your legally responsible natural/step/adoptive parent(s).
- (2) The CARE tool will determine your needs as met based on the guidelines outlined in the following table:

| | | Activities of Daily Living (ADLs) | | | | | | | | | | | | | | | | | |
|--|--|-----------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|
| | | Ages | | | | | | | | | | | | | | | | | |
| | | ■ = Code status as Met | | | | | | | | | | | | | | | | | |
| Medication Management | Independent, self-directed, administration required, or must be administered | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Locomotion in Room ^{Note} | Independent, supervision, limited or extensive | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |
| | Total | ■ | ■ | | | | | | | | | | | | | | | | |
| Locomotion Outside Room ^{Note} | Independent or supervision | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | |
| | Limited or extensive | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |
| | Total | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |
| Walk in Room ^{Note} | Independent, supervision, limited or extensive | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |
| | Total | ■ | ■ | | | | | | | | | | | | | | | | |
| Bed Mobility | Independent, supervision, limited or extensive | ■ | ■ | ■ | | | | | | | | | | | | | | | |
| | Total | ■ | ■ | | | | | | | | | | | | | | | | |
| Transfers | Independent, supervision, limited, extensive or total & under 30 pounds (Total & 30 pounds or more = no age limit) | ■ | ■ | ■ | | | | | | | | | | | | | | | |
| Toilet Use | Support provided for nighttime wetting only (independent, supervision, limited, extensive) | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | |
| | Independent, supervision, limited, extensive | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | |
| | Total | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |

| | | Activities of Daily Living (ADLs) | | | | | | | | | | | | | | | | | |
|--|--|-----------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|
| Ages | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| ■ = Code status as Met | | | | | | | | | | | | | | | | | | | |
| Eating | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | | | | | | | | | | | | | | | |
| Bathing | | | | | | | | | | | | | | | | | | | |
| Independent or supervision | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | |
| Physical help/transfer only or physical help/part of bathing | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | |
| Total | | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | | |
| Dressing | | | | | | | | | | | | | | | | | | | |
| Independent or supervision | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | |
| Limited or extensive | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | |
| Total | | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | | |
| Personal Hygiene | | | | | | | | | | | | | | | | | | | |
| Independent or supervision | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | |
| Limited or extensive | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | |
| Total | | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | | |

| | | Instrumental Activities of Daily Living | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|
| Ages | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| ■ = Code status as Met | | | | | | | | | | | | | | | | | | | |
| Telephone | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Transportation | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Shopping | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Wood Supply | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Housework | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Finances | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Meal Preparation | | | | | | | | | | | | | | | | | | | |
| Independent, supervision, limited, extensive, or total | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |

NOTE: If the activity did not occur, the department codes self performance as total and status as met.

| | | Ages | | | | | | | | | | | | | | | | | |
|---|--|------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|
| | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| Additional guidelines based on age | | | | | | | | | | | | | | | | | | | |
| Diagnosis Is client comatose? = No | | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | |
| Pain Daily = No | | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | |
| Any foot care needs | | | | | | | | | | | | | | | | | | | |
| Status = Need met | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Any skin care (other than feet) | | | | | | | | | | | | | | | | | | | |
| Status = Need met | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Speech/Hearing | | | | | | | | | | | | | | | | | | | |
| Score comprehension as understood | | ■ | ■ | ■ | | | | | | | | | | | | | | | |
| MMSE can be administered = no | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Memory | | | | | | | | | | | | | | | | | | | |
| Short term memory ok | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Long term memory ok | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Depression | | | | | | | | | | | | | | | | | | | |
| Select interview = unable to obtain | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Decision making | | | | | | | | | | | | | | | | | | | |
| Rate how client makes decisions = independent | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Bladder/Bowel | | | | | | | | | | | | | | | | | | | |
| Support provided for nighttime wetting only - Individual management = Does not need/use | | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ |
| Support provided for daytime wetting - Individual Management = Does not need/use | | ■ | ■ | ■ | ■ | ■ | ■ | | | | | | | | | | | | |
| Treatment | | | | | | | | | | | | | | | | | | | |
| Passive range of motion | | ■ | ■ | ■ | ■ | | | | | | | | | | | | | | |
| Need = No | | | | | | | | | | | | | | | | | | | |

(3) In addition, determine that the status and assistance available are met or partially met over three-fourths of the time, when you are living with your legally responsible natural/step/adoptive parent(s).

[Statutory Authority: RCW 74.08.090, 74.09.520. 07-24-026, § 388-106-0213, filed 11/28/07, effective 1/1/08; 07-10-024, § 388-106-0213, filed 4/23/07, effective 6/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0213, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0213, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0225 How do I pay for MPC? (1) If you live in your own home, you do not participate toward the cost of your personal care services.

(2) If you live in a residential facility and are:

(a) An SSI beneficiary who receives only SSI income, you only pay for board and room. You are allowed to keep a personal needs allowance of forty dollars and twelve cents per month;

(b) An SSI beneficiary who receives SSI and SSA benefits, you only pay for board and room. You are allowed to keep a personal needs allowance of forty dollars and twelve cents. You keep an additional twenty dollar disregard from non-SSI income;

(c) An SSI-related person under WAC 388-511-1105, you may be required to participate towards the cost of your personal care services in addition to your board and room if your financial eligibility is based on the facility's state contracted rate described in WAC 388-513-1305. You are allowed to keep a personal needs allowance of forty dollars and twelve cents. You keep an additional twenty dollar disregard from non-SSI income; or

(d) A GA-X client in a residential care facility, you are allowed to keep a personal allowance of only thirty-eight dollars and eighty-four cents per month. The remainder of your grant must be paid to the facility.

(3) The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the Medicaid resident dies in the facility; or

(b) Day of service before the day the Medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 2007-09 operating budget (SHB 1128). 07-21-020, § 388-106-0225, filed 10/8/07, effective 11/8/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0300 What services may I receive under community options program entry system (COPEs) when I live in my own home? When you live in your own home, you may be eligible to receive only the following services under COPEs:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service tasks in your own home, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands-on personal care;

(b) Are beyond the amount, duration or scope of Medicaid reimbursed home health services as described in WAC 388-551-2120 and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace Medicare home health services.

(6)(a) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if:

(i) You live alone in your own home;

(ii) You are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time; or

(iii) No one in your home, including you, can secure help in an emergency.

(b) A medication reminder if you:

(i) Are eligible for a PERS unit;

(ii) Do not have a caregiver available to provide the service; and

(iii) Are able to use the reminder to take your medications.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2100.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary for: Life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

- (a) Adjusting to a serious impairment;
- (b) Managing personal care needs; or
- (c) Developing necessary skills to deal with care providers.

(10) Transportation services, when the service:

- (a) Provides access to community services and resources to meet your therapeutic goal;
- (b) Is not diverting in nature; and
- (c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community.

(11) Nurse delegation services, when:

- (a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;
- (b) Your medical condition is considered stable and predictable by the delegating nurse; and
- (c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

- (a) Nursing assessment/reassessment;
- (b) Instruction to you and your providers;
- (c) Care coordination and referral to other health care providers;
- (d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.
- (e) File review; and/or
- (f) Evaluation of health-related care needs affecting service plan and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

- (a) May include: Safety deposits, utility set-up fees or deposits, health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution; and
- (b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0300, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0300, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0500 What services may I receive under medically needy in-home waiver (MNIW)? You

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may be eligible to receive only the following medically needy in-home waiver (MNIW) services in your own home:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands on personal care;

(b) Are beyond the amount, duration or scope of Medicaid reimbursed home health services (WAC 388-551-2120) and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace Medicare home health services.

(6)(a) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if:

(i) You live alone in your own home;

(ii) You are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time; or

(iii) No one in your home, including you, can secure help in an emergency.

(b) A medication reminder if you:

(i) Are eligible for a PERS unit;

(ii) Do not have a caregiver available to provide the service; and

(iii) Are able to use the reminder to take your medications.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2120.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(10) Transportation services if you live in your own home, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community.

(11) Nurse delegation services when:

(a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) Your medical condition is considered stable and predictable by the delegating nurse; and

(c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service planning and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0500, filed 11/28/07, effective 1/1/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0500, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0500, filed 5/17/05, effective 6/17/05.]

Chapter 388-310 WAC WORKFIRST

WAC

| | |
|--------------|--|
| 388-310-0300 | WorkFirst—Infant care exemptions for mandatory participants. |
| 388-310-1450 | Pregnancy to employment. |
| 388-310-1600 | WorkFirst—Sanctions. |
| 388-310-2100 | WorkFirst career services program. |

WAC 388-310-0300 WorkFirst—Infant care exemptions for mandatory participants. (1) When can I be exempted from participating in WorkFirst activities if I am a mandatory participant?

Either you or the other parent (living in the household) can claim an infant exemption from participating in WorkFirst activities provided you:

(a) Have a child under one year of age;

(b) Choose to not fully participate in the WorkFirst program (see WAC 388-310-0400); and

(c) Have not used up your lifetime twelve-month infant exemption.

(2) If I choose my infant exemption, can I still be required to participate in the WorkFirst program?

You are required to participate up to twenty hours per week in mental health and/or chemical dependency treatment if:

(a) The comprehensive evaluation or assessment indicates a need; and

(b) Services are available in your community.

(3) Can I volunteer to participate in WorkFirst while I have a child under one?

You may choose to fully participate in WorkFirst (see WAC 388-310-0400) while you have a child under one year of age. If you decide later to stop participating and you still qualify for an exemption, you will be put back into exempt status with no financial penalty provided you meet conditions (1) and (2) above.

(4) Does an infant exemption from participation affect my sixty-month time limit for receiving TANF or SFA benefits?

Even if you are exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit (see WAC 388-484-0005).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.055 and 2007 c 289, 08-02-055, § 388-310-0300, filed 12/28/07, effective 2/1/08. Statutory Authority: RCW 74.08.090, 74.04.050, 02-14-087, § 388-310-0300, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-0300, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0300, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1450 Pregnancy to employment. (1) How do I know if I am eligible to participate in pregnancy to employment?

If you are on TANF/SFA and are pregnant or have a child under the age of one year, you are a participant in the pregnancy to employment pathway.

(2) What services are provided to the pregnancy to employment pathway?

(a) The pregnancy to employment pathway provides you with services, when available in your community, to help you learn how to work, look for work, or prepare for work while still meeting your child's needs. You and your case manager or social worker will decide which variety of services you need such as:

- (i) Parenting education or parenting skills training;
- (ii) Safe and appropriate child care;
- (iii) Mental health treatment;
- (iv) Chemical dependency treatment;
- (v) Domestic violence services; or
- (vi) Employment services.

(b) The case manager or social worker will contact you every three months to offer you services if you are not required to participate and choose to claim the infant exemption.

(3) What am I required to do while I am in the pregnancy to employment pathway?

You must participate in an assessment with a DSHS social worker and based on the results you will:

(a) Work with your case manager/social worker to decide which required activities best meet your needs. These activities will depend on where you are in the pregnancy or the age of your child and will be added to your individual responsibility plan (IRP).

(b) Be required to participate in the activities identified in your IRP.

(4) What am I required to do while I am pregnant?

Based upon the results of your assessment, your participation:

(a) During your first and second trimester of pregnancy will be full-time work, looking for work, or preparing for work unless you have a good reason to participate fewer hours (see WAC 388-310-1600).

(b) During your third trimester of pregnancy will be up to twenty hours per week in mental health and/or chemical dependency treatment if:

- (i) The comprehensive evaluation or assessment indicates a need; and
- (ii) Services are available in your community.

(5) What am I required to do after my child is born?

After the birth of your child, you may choose to take the infant exemption (See WAC 388-310-0300) or volunteer to participate in WorkFirst activities to the fullest of your abilities (see WAC 388-310-0400).

(6) What if I have used my twelve-month lifetime infant exemption?

If you have another child after using all twelve months of the infant exemption, you will be:

(a) Eligible for a twelve-week postpartum deferral period to personally take care of an infant less than twelve weeks of age. During the twelve-week postpartum deferral period, you will be required to participate up to twenty hours per week in mental health and/or chemical dependency treatment if the comprehensive evaluation or assessment indicates a need and services are available in your community.

(b) Required (unless otherwise exempt or you have good reason to participate fewer hours) to participate full-time, once your child turns twelve-weeks old. Activities in which you are required to participate include one or more of the following:

- (i) Work;
- (ii) Looking for work; or
- (iii) Preparing for work by participating in a combination of activities based upon the results of your assessment.

(7) Will I be sanctioned if I refuse to participate?

(a) You are required to participate in the WorkFirst program (see WAC 388-310-0200) subject to sanction (see WAC 388-310-1600) unless you have good reason and you:

- (i) Are in your third trimester of pregnancy; or
- (ii) Have not used up your twelve-month lifetime infant exemption and have a child under the age of one year; or
- (iii) Have used up your twelve-month lifetime infant exemption and have a child under twelve weeks.

(b) You may be sanctioned if you stop participating in required mental health and/or chemical dependency treatment even if you are in your third trimester, claiming the infant exemption, or using a twelve-week postpartum deferral period.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.055 and 2007 c 289, 08-02-055, § 388-310-1450, filed 12/28/07, effective 2/1/08. Statutory Authority: RCW 74.08.090, 74.04.050, 02-14-087, § 388-310-1450, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-1450, filed 3/1/00, effective 3/1/00.]

WAC 388-310-1600 WorkFirst—Sanctions. (1) What WorkFirst requirements do I have to meet?

You must do the following when you are a mandatory WorkFirst participant:

(a) Give the department the information we need to develop your individual responsibility plan (IRP) (see WAC 388-310-0500);

(b) Show that you are participating fully to meet all of the requirements listed on your individual responsibility plan;

(c) Go to scheduled appointments listed in your individual responsibility plan;

(d) Follow the participation and attendance rules of the people who provide your assigned WorkFirst services or activities; and

(e) Accept available paid employment when it meets the criteria in WAC 388-310-1500.

(2) What happens if I don't meet WorkFirst requirements?

(a) If you do not meet WorkFirst requirements, we will send you a letter telling you what you did not do.

(b) You will have ten days to contact us so we can talk with you about the situation. You can contact us in writing, by phone, by going to the appointment described in the letter, or by asking for an individual appointment.

(c) If you do not contact us within ten days, we will make sure you have been screened for family violence and other barriers to participation. We will use existing information to decide whether:

- (i) You were unable to do what was required; or
- (ii) You were able, but refused, to do what was required.
- (d) If you had a good reason not to do a required activity we will work with you and may change the requirements in

your individual responsibility plan if a different WorkFirst activity would help you move towards independence and employment sooner. If you have been unable to meet your WorkFirst requirements because of family violence, you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

(e) Before you are placed in sanction:

(i) We will have a case staffing which is a meeting with you, your case manager and other people involved in your case to review your situation and make plans. At your case staffing, we will ensure you were offered the opportunity to participate, discuss what happens if you stay in sanction, discuss how participation helps you and your family and discuss how to end your sanction. You will be notified when your case staffing is going to happen so you can attend. You can invite anyone you want to come with you to your case staffing.

(ii) Effective September 1, 2006, supervisory staff will review your case and must approve the sanction.

(f) If you are sanctioned, we will actively attempt to contact you another way so we can talk to you about the benefits of participation and how to end your sanction.

(3) What is considered a good reason for not being able to do what WorkFirst requires?

You have a good reason if it was not possible to do what WorkFirst requires (or get an excused absence, described in WAC 388-310-0500(5)) due to a significant problem or event outside your control. Some examples of good reasons include, but are not limited to:

(a) You had an emergent or severe physical, mental or emotional condition, confirmed by a licensed health care professional that interfered with your ability to participate;

(b) You were threatened with or subjected to family violence;

(c) You could not locate child care for your children under thirteen years that was:

(i) Affordable (did not cost you more than your co-payment would under the working connections child care program in chapter 388-290 WAC);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(iv) You could not locate other care services for an incapacitated person who lives with you and your children.

(d) You had an immediate legal problem, such as an eviction notice; or

(e) You are a person who gets necessary supplemental accommodation (NSA) services under chapter 388-472 WAC and your limitation kept you from participating. If you have a good reason because you need NSA services, we will review your accommodation plan.

(4) What if we decide that you did not have a good reason for failing to meet WorkFirst requirements?

If we decide that you did not have a good reason for failing to meet WorkFirst requirements, we will send you a letter that tells you:

(a) What you failed to do;

(b) That you are in sanction status;

(c) Penalties that will be applied to your grant;

(d) When the penalties will be applied;

(e) How to request a fair hearing if you disagree with this decision; and

(f) How to end the penalties and get out of sanction status.

(5) What is sanction status?

When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't comply and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

(6) Are there penalties when you or someone in my household goes into sanction status?

(a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.

(b) Your grant is reduced by the person(s) share or forty percent, whichever is more.

(7) How do I end the penalties and get out of sanction status?

To stop the penalties and get out of sanction status:

(a) You must provide the information we requested to develop your individual responsibility plan; and/or

(b) Start and continue to do your required WorkFirst activities for four weeks in a row (that is, twenty-eight calendar days).

(c) When you leave sanction status, your grant will be restored to the level for which you are eligible beginning the first of the month following your four weeks of participation. For example, if you finished your four weeks of participation on June 15, your grant would be restored on July 1.

(8) What if I reapply for TANF or SFA and I was in sanction status when my case closed?

(a) If your case closes while you are in sanction status and is reopened in six months or less, you will start out in sanction.

(b) Effective September 1, 2006, if you come back in sanction, you will start out where you left off in sanction. (That is, if you left off in month three of sanction, you will come back on in month four of sanction.)

(c) If your case has been closed for more than six months, you will not be in sanction status if your case is reopened.

(9) What happens effective September 1, 2006 if I stay in sanction status? Effective September 1, 2006, if you stay in sanction status:

(a) Unless you are a dependent child age sixteen or older, your case manager will review your record after you have been in sanction for at least three months in a row to make sure:

(i) You knew what was required;

(ii) You were told how to end your sanction;

(iii) We tried to talk to you and to encourage you to participate; and

(iv) You were given a chance to tell us if you were unable to do what we required.

(b) Your case manager will invite you to a noncompliance sanction case staffing.

(i) You will be notified when your noncompliance sanction case staffing is going to happen so you can attend.

(ii) Your case manager will also invite other people who are working with your family to your noncompliance sanction case staffing, like representatives from tribes, community or technical colleges, employment security, the children's administration or limited-English proficient (LEP) pathway providers.

(iii) You can invite anyone you want to come with you to your case staffing.

(c) At your noncompliance sanction case staffing, we will discuss with you:

(i) How you and your family benefit when you participate in WorkFirst activities;

(ii) How you can participate, and get out of sanction;

(iii) That if you continue to refuse to participate, without good cause, a sanction review panel may review your case, and decide to close your case after you have been in sanction status for six months in a row.

(iv) How you plan to care for and support your children if a sanction review panel closes your case. We will also discuss the safety of your family, as needed, using the guidelines under RCW 26.44.030; and

(v) How to reapply if a sanction review panel closes your case.

(d) If you do not come to your noncompliance sanction case staffing, we will make a decision based on the information we have. We will also attempt to visit you at your home so you have another chance to talk to us about the benefits of participation and how to end your sanction.

(e) If we decide you are refusing to participate without a good reason:

(i) We will send you information about resources you may need if a sanction review panel closes your case;

(ii) We will send information to a sanction review panel with a recommendation to close your case. We will only do this after a community services office administrator reviews your case to make sure the sanction is appropriate and we tried to reengage you in the program; and

(iii) The sanction review panel will review your case and make the final decision.

(10) What is a sanction review panel?

(a) The sanction review panel is a small group of people who are independent of your local community services office and do a thorough, objective review of your sanction.

(b) The sanction review panel makes the final decision about whether to close your case after receiving a recommendation from your case manager and reviewing your case to make sure the original sanction was appropriate and we made attempts to reengage you in the program.

(11) What happens when a sanction review panel decides to close my case?

When a sanction review panel decides to close your case, we will send you a letter to tell you:

(a) What you failed to do;

(b) When your case will be closed;

(c) How to request a fair hearing if you disagree with this decision;

(d) How to end your penalties and keep your case open (if you are able to participate for four weeks in a row before we close your case); and

(e) How your participation before your case is closed can be used to meet the participation requirement in subsection (12).

(12) What if I reapply for TANF or SFA after a sanction review panel closed my case?

(a) If a sanction review panel closes your case and you apply within six months, you must participate for four weeks in a row before you can receive cash. Once you have met your four week participation requirement, your cash benefits will start, going back to the date we had all the other information we needed to make an eligibility decision.

(b) You will not be required to participate for four weeks in a row before you receive cash if you apply after your case has been closed for six months or longer.

(13) What if my TANF or SFA is closed by a sanction review panel, reopened and I go into sanction again?

(a) When a sanction review panel closes your case, and we reopen your case, we will follow all steps in subsection (9) of this section (like the case review and the noncompliance case staffing) during your second month of sanction.

(b) The sanction review panel may close your case after you are in sanction status for three months in a row.

(c) If your case is closed, and you reapply, we will follow the rules in subsection (12) of this section to reopen your case.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090. 07-09-081, § 388-310-1600, filed 4/17/07, effective 6/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-1600, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 04-07-025, § 388-310-1600, filed 3/8/04, effective 5/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-2100 WorkFirst career services program. (1) What is the WorkFirst career services program?

The WorkFirst career services program is available to employed adults who leave temporary assistance for needy families (TANF) or state family assistance (SFA) and are working thirty hours or more per week. The employment security department administers the program.

WorkFirst career services provide up to six months of:

- Basic needs payments;
- Wage progression services; and
- Job retention services.

(2) Who is eligible for the WorkFirst career services program?

(a) To qualify for the program, you must enroll with the employment security department within the first two months after your TANF/SFA ends.

(b) You must also meet the following conditions:

(i) You are working thirty hours or more per week in a paid unsubsidized job; and

(ii) You are a custodial parent or caretaker relative who received TANF/SFA within the past two months; and

(iii) You did not leave TANF/SFA in sanction status.

(c) Each adult in your family who meets these conditions and enrolls in the program will receive their own basic needs payments and services.

(3) What services and basic needs payments are available while I am enrolled in the WorkFirst career services program?

The WorkFirst career services program provides wage progression services, job retention services and basic needs payments.

(a) Services include employment planning that will help you keep your job and increase your wages.

(b) As shown in the chart below, cash payments and bonuses are made monthly, for up to six consecutive months after leaving TANF/SFA.

(c) You may receive up to six hundred fifty dollars in cash payments and bonuses over the six-month period following your TANF/SFA case closing.

| Eligible Month | Payments & Bonus Amounts | Description of Payments and Bonuses |
|--------------------------|--------------------------------------|--|
| Month 1-6 After TANF/SFA | \$50.00 a month | Monthly payments begin once you enroll. If you enroll during Month 2, then you are not eligible for the Month 1 payment. |
| Month 1 or 2 | \$150.00 | One-time enrollment bonus when you sign up for the program. |
| Month 4 and 6 | \$100.00 month 4 \$100.00 month 6 | Bonus for completing the WorkFirst career services assessment and employment planning interview. |

(4) How long can I receive WorkFirst career services and basic needs payments?

(a) WorkFirst career services and basic needs payments are available for a maximum of six consecutive months. Month one begins the calendar month after your TANF/SFA assistance ends.

(b) Your WorkFirst career services and basic needs payments will stop when:

- (i) We learn you are no longer working thirty hours a week in unsubsidized employment; or
- (ii) You begin receiving TANF/SFA assistance again; or
- (iii) We do not have your current mailing address; or
- (iv) You are not living in Washington; or
- (v) It has been more than six months since you stopped receiving TANF/SFA.

(5) What happens if the employment security department learns I am no longer working thirty hours or more per week?

(a) The employment security department will provide you with a letter giving you at least ten days advance notice

that your WorkFirst career services will close. This means that your WorkFirst career services basic needs payments will stop at the end of the month in which your ten days notice expires. The letter will tell you how to request an administrative hearing if you disagree with the decision.

(b) If you find a new job or increase your hours back up to thirty hours before the end of the month, you will remain eligible.

(c) Employment security staff can help you find new employment or work with you to increase your hours of employment.

(6) What happens if I am approved for TANF/SFA assistance while I am receiving WorkFirst career services?

If you start receiving TANF/SFA assistance, the employment security department will provide you with a letter and close your WorkFirst career services case at the end of the month. The letter will tell you how to request an administrative hearing if you disagree with the decision.

(7) What happens if I request an administrative hearing?

(a) You have the right to request an administrative hearing if you disagree with a decision or action regarding the WorkFirst career services Program. For more information, see chapter 388-02 WAC and RCW 74.08.080.

(b) If you receive continued benefits, they will still end when you reach your benefit maximum as outlined under (3)(c) regardless of any other pending administrative hearing.

[Statutory Authority: RCW 74.04.050, 74.04.055, and 2007 c 522. 07-20-042, § 388-310-2100, filed 9/26/07, effective 10/27/07.]

**Chapter 388-406 WAC
APPLICATIONS**

WAC

388-406-0040

What happens if the processing of my application is delayed?

WAC 388-406-0040 What happens if the processing of my application is delayed?

(1) We process your application for benefits as soon as possible. We do not intentionally delay processing your application for benefits for any reason. If we have enough information to decide eligibility for:

(a) Basic Food, we promptly process your request for benefits even if we need more information to determine eligibility for cash or medical;

(b) Medical assistance, we promptly process your request for medical even if we need more information to determine eligibility for cash or Basic Food.

(2) If you have completed your required interview under WAC 388-452-0005 and we have enough information to determine eligibility, then we promptly process your application even if it is after thirty days from the date of your application.

(3) If additional information is needed to determine eligibility, we give you:

- (a) A written request for the additional information; and
- (b) An additional thirty days to provide the information.

(4) If you fail to keep or reschedule your interview in the first thirty calendar days after filing your application, your application will be denied on the thirtieth day, or the first

business day after the thirtieth day. If you are still interested in Basic Food benefits, you will need to reapply. Benefits will be based on your second application date.

(5) If we have not processed your application for Basic Food by the sixtieth day and:

(a) You are responsible for the delay, we deny your request for benefits.

(b) If we are responsible for the delay, we:

(i) Promptly process your request if we have the information needed to determine eligibility; or

(ii) Deny your request if we don't have enough information to determine eligibility. If we deny your request we notify you of your right to file a new application and that you may be entitled to benefits lost.

(6) If you reapply by the sixtieth day of your first application, met your interview requirements under WAC 388-452-0005, and are eligible, we give you benefits lost from:

(a) The date of your first application if we caused the delay in the first thirty days; or

(b) The month following the month of your first application if you caused the delay in the first thirty days.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 07-13-019, § 388-406-0040, filed 6/11/07, effective 7/12/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-039, § 388-406-0040, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090, 02-14-023, § 388-406-0040, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

Chapter 388-408 WAC ASSISTANCE UNITS

WAC

388-408-0055 Medical assistance units.

WAC 388-408-0055 Medical assistance units. (1) One or more medical assistance units (MAU) is established for individuals living in the same household based on the type of medical program, each individual's relationship to other family members, and the individual's financial responsibility for the other family members.

(2) Financial responsibility applies only to spouses and to parents, as follows:

(a) Married persons, living together are financially responsible for each other; and

(b) Persons who meet the definition of a natural, adoptive, or step-parent described in WAC 388-454-0010 are financially responsible for their unmarried, minor children living in the same household.

(3) Minor children are not financially responsible for their parents or for their siblings.

(4) When determining eligibility for family, pregnancy, or children's medical programs, follow the income rules as described in WAC 388-450-0106 (1) through (7). Only one MAU is required when all family members are eligible for categorically needy (CN) medical coverage.

(5) If a family is not eligible as one MAU for a CN program, separate MAUs are required for family members living in the same household in the following situations:

(a) A pregnant minor, regardless of whether she lives with her parent(s);

(b) A child with earned or unearned income;

(c) A child with resources which make another family member ineligible for medical assistance;

(d) A child of unmarried parents when both parents reside with the child;

(e) Each unmarried parent of a child in common, plus any of their children who are not in separate MAUs;

(f) A caretaker relative that is not financially responsible for the support of the child;

(6) For a family with multiple MAUs established based on the criteria described in subsection (5) of this section, a parent's:

(a) Income up to one hundred percent of the Federal Poverty Level (FPL) is allocated to the parent and other members of the parent's MAU. The excess is allocated to their children in separate MAUs.

(b) Resources are allocated equally to the parent and all persons in the parent's household for whom the parent is financially responsible. This includes family members in separate MAUs.

(7) The exceptions to the income allocations described in subsection (6) of this section are as follows:

(a) Only the parent's income actually contributed to a pregnant minor is considered income to the minor.

(b) A parent's financial responsibility is limited when the minor child is receiving inpatient chemical dependency or mental health treatment. Only the income a parent chooses to contribute to the child is considered available when:

(i) The treatment is expected to last ninety days or more;

(ii) The child is in court-ordered, out-of-home care in accordance with chapter 13.34 RCW; or

(iii) The department determines the parents are not exercising responsibility for the care and control of the child.

(8) When determining eligibility for an SSI-related medical program, a separate MAU is required for:

(a) SSI recipients;

(b) An SSI-related person who has not been found eligible for family medical under this chapter; or

(c) The purpose of applying medical income standards for an:

(i) SSI-related applicant whose spouse is not relatable to SSI or is not applying for SSI-related medical; and

(ii) Ineligible spouse of an SSI recipient.

(9) For a person in a separate MAU, based on the criteria described in subsection (8) of this section, the income and resource allocations described in subsection (6) of this section are not used. The SSI-related individual's eligibility is determined using the allocations or deeming rules in chapter 388-475 WAC.

(10) Countable income for medical programs:

(a) For SSI individuals is described in chapter 388-475 WAC; or

(b) For family medical, pregnancy medical, and children's medical is described in WAC 388-450-0210.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 74.09.055 as amended by 2006 c 24, 07-11-044, § 388-408-0055, filed 5/9/07, effective 6/9/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530, 06-04-021, § 388-408-0055, filed 1/23/06, effective 2/23/06. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-408-0055, filed 8/12/02, effective 9/12/02.]

Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610, 388-506-0630 and 388-507-0730.]

Chapter 388-412 WAC BENEFIT ISSUANCES

WAC

388-412-0025 How do I get my benefits?

WAC 388-412-0025 How do I get my benefits? (1)

We send your cash benefits to you by either:

(a) Electronic benefit transfer (EBT), which is a direct deposit into a DSHS account that you access with a debit card called the Washington EBT Quest card;

(b) Electronic funds transfer (EFT), which is a direct deposit into your own bank account;

(c) A warrant (check) to a payee who is not approved for direct deposit; or

(d) A warrant (check) to you if you get:

(i) Diversion cash assistance (DCA) that cannot be paid directly to a vendor;

(ii) Additional requirements for emergent needs (AREN) that cannot be paid directly to a vendor;

(iii) Ongoing additional requirements (OAR) that cannot be paid directly to a vendor;

(iv) Clothing and personal incidentals (CPI) payments; or

(v) State supplemental payment (SSP) and you do not receive your benefit through EFT.

(2) We send your **Basic Food** benefits to you by EBT.

(3) We set up an EBT account for the head of household of each AU that receives benefits by EBT.

(4) You use a Quest debit card to access your benefits in your EBT account. You select a personal identification number (PIN) that you must enter when using this card.

(5) You must use your cash and Basic Food benefits from your EBT account. We do not convert cash or Basic Food benefits to checks.

(6) We deposit your Basic Food benefits into your EBT account by the tenth day of the month based on your Basic Food assistance unit number as described in WAC 388-412-0020.

(7) **Unused EBT benefits:** If you do not use your EBT account for three hundred sixty-five days, we cancel the cash and Basic Food benefits on your account.

(a) Replacing Basic Food benefits:

(i) We **can replace** cancelled benefits we deposited **less than three hundred sixty-five days** from the date you ask for us to replace your benefits.

(ii) We **cannot replace** cancelled benefits deposited **three hundred sixty-five or more days** from the date you ask us to replace your benefits.

(b) **Replacing cash benefits:** We **can replace** cancelled cash benefits for you or another member of your assistance unit. Cash benefits are not transferable to someone outside of your assistance unit.

(8) **Replacing cash warrants:** If we issued you cash benefits as a warrant we can replace these benefits for you or a member of your assistance unit. Cash benefits are not transferable to someone outside of your assistance unit.

(a) If we issued the benefits as a warrant one hundred sixty or fewer days ago, your local office can replace the warrant.

(b) If we issued the benefits as a warrant more than one hundred sixty days ago, the Office of Accounting Services can replace the warrant.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, and 7 C.F.R. 274.12. 07-04-029, § 388-412-0025, filed 1/29/07, effective 3/1/07. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-089, § 388-412-0025, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0025, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510 and 74.08.090. 02-18-105, § 388-412-0025, filed 9/3/02, effective 10/4/02; 01-18-054, § 388-412-0025, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-418 WAC CHANGE OF CIRCUMSTANCE

WAC

388-418-0005

388-418-0011

How will I know what changes I must report?

What is a mid-certification review, and do I have to complete one in order to keep receiving benefits?

WAC 388-418-0005 How will I know what changes I must report? You must report changes to the department based on the kinds of assistance you receive. The set of changes you must report for people in your assistance unit under chapter 388-408 WAC is based on the benefits you receive that require you to report the most changes. It is the first program that you receive benefits from in the list below.

For example:

If you receive long term care and Basic Food benefits, you tell us about changes based on the long term care requirements because it is the first program in the list below you receive benefits from.

(1) If you receive long term care benefits such as Basic, Basic Plus, chore, community protection, COPEs, nursing home, Hospice, or medically needy waiver, you must tell us if you have a change of:

(a) Address;

(b) Marital status;

(c) Living arrangement;

(d) Income;

(e) Resources;

(f) Medical expenses; and

(g) If we allow you expenses for your spouse or dependents, you must report changes in their income or shelter cost.

(2) If you receive medical benefits based on age, blindness, or disability (SSI-related medical), or ADATSA benefits, you need to tell us if:

(a) You move;

(b) A family member moves into or out of your home;

(c) Your resources change; or

(d) Your income changes. This includes the income of you, your spouse or your child living with you.

(3) If you receive Basic Food and all adults in your assistance unit are elderly persons or individuals with disabilities and have no earned income, you need to tell us if:

(a) You move;

(b) You start getting money from a new source;

- (c) Your income changes by more than fifty dollars;
- (d) Your liquid resources, such as your cash on hand or bank accounts, are more than two thousand dollars; or
- (e) Someone moves into or out of your home.
- (4) If you receive cash benefits other than WorkFirst career services benefits, you need to tell us if:
 - (a) You move;
 - (b) Someone moves out of your home;
 - (c) Your total gross monthly income goes over the:
 - (i) Payment standard under WAC 388-478-0030 if you receive general assistance; or
 - (ii) Earned income limit under WAC 388-478-0035 and 388-450-0165 for all other programs;
 - (d) You have liquid resources more than four thousand dollars; or
 - (e) You have a change in employment. Tell us if you:
 - (i) Get a job or change employers;
 - (ii) Change from part-time to full-time or full-time to part-time;
 - (iii) Have a change in your hourly wage rate or salary; or
 - (iv) Stop working.
- (5) If you receive family medical benefits, you need to tell us if:
 - (a) You move;
 - (b) A family member moves out of your home; or
 - (c) If your income goes up or down by one hundred dollars or more a month and you expect this income change will continue for at least two months.
- (6) If you receive Basic Food benefits, you need to tell us if:
 - (a) You move;
 - (b) Your total gross monthly income is more than the gross monthly income limit under WAC 388-478-0060; or
 - (c) Anyone who receives food benefits in your assistance unit must meet work requirements under WAC 388-444-0030 and their hours at work go below twenty hours per week.
- (7) If you receive children's medical benefits, you need to tell us if:
 - (a) You move; or
 - (b) A family member moves out of the house.
- (8) If you receive pregnancy medical benefits, you need to tell us if:
 - (a) You move; or
 - (b) You are no longer pregnant.
- (9) If you receive other medical benefits, you need to tell us if:
 - (a) You move; or
 - (b) A family member moves out of the home.
- (10) If you receive transitional food assistance or Work-First career services benefits, you do not have to report any changes in your circumstances.

[Statutory Authority: RCW 74.04.050, 74.04.055, and 2007 c 522. 07-20-042, § 388-418-0005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A-010. 05-19-060, § 388-418-0005, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 44.04.280. 05-09-021, § 388-418-0005, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-026, § 388-418-0005, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-026, § 388-418-0005, filed 2/23/04, effective 3/25/04; 03-21-028, § 388-418-0005, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and

74.04.510. 01-11-109, § 388-418-0005, filed 5/21/01, effective 7/1/01; 99-23-034, § 388-418-0005, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0011 What is a mid-certification review, and do I have to complete one in order to keep receiving benefits? (1) **A mid-certification review (MCR)** is a form we send you to ask about your current circumstances. We use the answers you give us to decide if you are still eligible for benefits and to calculate your monthly benefits.

(2) If you receive cash assistance, family-related medical, or Basic Food benefits, you must complete a mid-certification review unless you meet one of the exceptions below:

(a) You **do not** have to complete a mid-certification review for cash assistance if you:

(i) Only receive Refugee Cash Assistance as described under WAC 388-400-0030; or

(ii) Have a review period of six months or less.

(b) You **do not** have to complete a mid-certification review for Basic food if:

(i) Your assistance unit has a certification period of six months or less; or

(ii) All adults in your assistance unit are elderly or disabled and have no earned income.

(3) When we send the review form:

| If you must complete a MCR... | We send your review form... |
|--|--|
| (a) For one program such as Basic Food or Family Medical. | In the fifth month of your certification or review period. You must complete your review by the 10th day of month six. |
| (b) For two or more programs, and all programs have a 12-month certification or review period. | In the fifth month of your certification or review period. You must complete your review by the 10th day of month six. |
| (c) For Basic Food and another program when either program has a certification or review period between six and twelve months. | In the fifth month of your Basic Food certification period when you receive Basic Food and another program. You must complete your review by the 10th day of month six of your Basic Food certification. |

(4) If you must complete a mid-certification review, we send you the review form with questions about your current circumstances. You can choose to complete the review in one of the following ways:

(a) **Complete the form and return it to us.** For us to count your mid-certification review as complete, you must take all of the steps below:

(i) Complete the review form, telling us about changes in your circumstances we ask about;

(ii) Sign and date the form;

(iii) Give us proof of any changes you report. If you report a change that will increase your benefits without giving proof of this change, we will not increase your benefits;

(iv) If you receive family medical benefits, give us proof of your income even if it has not changed;

(v) If you receive temporary assistance for needy families and you are working or self employed, you must give us proof of your income even if it has not changed; and

(vi) Mail or turn in the completed form and any required proof to us by the due date on the review.

(b) **Complete the mid-certification review over the phone.** For us to count your mid-certification review as complete, you must take all of the steps below:

(i) Contact us at the phone number on the review form, telling us about changes in your circumstances we ask about;

(ii) Give us proof of any changes you report. We may be able to verify some information over the phone. If you report a change that will increase your benefits without giving proof of this change, we will not increase your benefits;

(iii) If you receive family medical benefits, give us proof of your income even if it has not changed;

(iv) If you receive temporary assistance for needy families and you are working or self employed, you must give us proof of your income even if it has not changed; and

(v) Mail or turn in any required proof to us by the due date on the review.

(c) **Complete the application process for another program.** If we approve an application for another program in the month you must complete your mid-certification review, we use the application to complete your review when the same person is head of household for the application and the mid-certification review.

(5) If your benefits change because of what we learned in your mid-certification review, the change takes effect the next month even if this does not give you ten days notice before we change your benefits.

(6) If you do not complete your required mid-certification review, we stop your benefits at the end of the month the review was due.

(7) **Late reviews.** If you complete the mid-certification review after the last day of the month the review was due, we process the review as described below based on when we receive the review:

(a) **Mid-certification reviews you complete by the last day of the month after the month the review was due:** We determine your eligibility for ongoing benefits. If you are eligible, we reinstate your benefits based on the information in the review.

(b) **Mid-certification reviews you complete after the last day of the month after the month the review was due:** We treat this review as a request to send you an application. For us to determine if you are eligible for benefits, you must complete the application process as described in chapter 388-406 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and Public Law 109-171, TANF Interim Final Rule published in the Federal Register - Volume 71, No. 125 on June 29, 2006. 08-02-053, § 388-418-0011, filed 12/28/07, effective 2/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-24-025 and 07-01-023, § 388-418-0011, filed 11/29/06 and 12/8/06, effective 10/1/07; 06-13-043, § 388-418-0011, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-09-020, § 388-418-0011, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-19-134, § 388-418-0011, filed 9/21/04, effective 10/1/04.]

Chapter 388-424 WAC CITIZENSHIP/ALIEN STATUS

WAC

388-424-0006 Citizenship and alien status—Date of entry.

WAC 388-424-0006 Citizenship and alien status—Date of entry. (1) A person who physically entered the U.S. prior to August 22, 1996 and who continuously resided in the U.S. prior to becoming a "qualified alien" (as defined in WAC 388-424-0001) is not subject to the five-year bar on TANF, nonemergency Medicaid, and SCHIP.

(2) A person who entered the U.S. prior to August 22, 1996 but became "qualified" on or after August 22, 1996, or who physically entered the U.S. on or after August 22, 1996 and who requires five years of residency to be eligible for federal Basic Food, can only count years of residence during which they were a "qualified alien."

(3) A person who physically entered the U.S. on or after August 22, 1996 is subject to the five-year bar on TANF, nonemergency Medicaid, and SCHIP unless exempt. The five-year bar starts on the date that "qualified" status is obtained.

(4) The following "qualified aliens," as defined in WAC 388-424-0001, are exempt from the five-year bar:

(a) Amerasian lawful permanent residents;

(b) Asylees;

(c) Cuban/Haitian entrants;

(d) Persons granted withholding of deportation or removal;

(e) Refugees;

(f) Victims of trafficking who have been certified or had their eligibility approved by the office of refugee resettlement (ORR); and

(g) Lawful permanent residents, parolees, or battered aliens, as defined in WAC 388-424-0001, who are also an armed services member or veteran as described in WAC 388-424-0007.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-023, § 388-424-0006, filed 3/9/07, effective 4/9/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-16-055, § 388-424-0006, filed 7/28/05, effective 8/28/05; 04-15-004, § 388-424-0006, filed 7/7/04, effective 8/7/04.]

Chapter 388-436 WAC EMERGENCY CASH ASSISTANCE

WAC

388-436-0015 Consolidated emergency assistance program (CEAP).
388-436-0030 Eligibility for CEAP depends on other possible cash benefits.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-436-0025 Eligibility conditions for CEAP—Job refusal. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0025, filed 7/31/98, effective 9/1/98.] Repealed by 07-07-103, filed 3/19/07, effective 4/19/07. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.08.090.

WAC 388-436-0015 Consolidated emergency assistance program (CEAP). (1) CEAP is available to the following persons:

(a) A pregnant woman in any stage of pregnancy; or
 (b) Families with dependent children, including, within available funds, families who have stopped receiving their TANF grant within the last six months under WAC 388-310-1600.

(2) Applicants must be residents of Washington state as defined in WAC 388-468-0005.

(3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:

- (a) Food;
- (b) Shelter;
- (c) Clothing;
- (d) Minor medical care;
- (e) Utilities;
- (f) Household maintenance supplies;
- (g) Necessary clothing or transportation costs to accept or retain a job; or

(h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.

(4) Payment under this program is limited to not more than thirty consecutive days within a period of twelve consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 07-07-103, § 388-436-0015, filed 3/19/07, effective 4/19/07. Statutory Authority: RCW 74.04.050, 74.04.055, and 74.04.057. 04-05-013, § 388-436-0015, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits. (1) Before the department approves CEAP benefits, we must determine that all household members are ineligible for benefits from any of the following programs:

(a) Temporary assistance for needy families (TANF) or state family assistance (SFA), unless the family has had its cash grant terminated under WAC 388-310-1600 within the last six months;

- (b) Refugee cash assistance (RCA);
- (c) Diversion cash assistance (DCA).

(2) To receive CEAP, the applicant must take any required action to receive benefits from the following programs:

(a) TANF or SFA, unless the family has had its case grant terminated under WAC 388-310-1600 within the last six months;

- (b) RCA;
- (c) Supplemental security income (SSI);
- (d) Medical assistance for those applicants requesting help for a medical need;

(e) Food assistance for those applicants requesting help for a food need;

(f) Housing assistance from any available source for those applicants requesting help for a housing need;

(g) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(3) The department may not authorize CEAP benefits to any household containing a member who is receiving reduced cash benefits for failure to comply with program requirements of TANF/SFA or RCA. This restriction does not apply to families who have stopped receiving TANF cash benefits under WAC 388-310-1600 within the last six months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 07-07-103, § 388-436-0030, filed 3/19/07, effective 4/19/07. Statutory Authority: RCW 74.04.660. 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC

EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0110 The alien emergency medical (AEM) program.

WAC 388-438-0110 The alien emergency medical (AEM) program. (1) The alien emergency medical (AEM) program is a required federally funded program. It is for aliens who are ineligible for other Medicaid programs, due to the citizenship or alien status requirements described in WAC 388-424-0010.

(2) Except for the Social Security number, citizenship, or alien status requirements, an alien must meet categorical Medicaid eligibility requirements as described in:

- (a) WAC 388-505-0110, for an SSI-related person;
- (b) WAC 388-505-0220, for family medical programs;
- (c) WAC 388-505-0210, for a child under the age of nineteen; or
- (d) WAC 388-523-0100, for medical extensions.

(3) When an alien has monthly income that exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who are age sixty-five or over or who meet SSI disability criteria. See WAC 388-519-0100.

(4) To qualify for the AEM program, the alien must meet one of the criteria described in subsection (2) of this section and have a qualifying emergency medical condition as described in WAC 388-500-0005.

(5) The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.

(6) The department does not deem a sponsor's income and resources as available to the client when determining eligibility for the AEM program. The department counts only the income and resources a sponsor makes available to the client.

(7) Under the AEM program, covered services are limited to those medical services necessary for treatment of the person's emergency medical condition. The following services are not covered:

- (a) Organ transplants and related services;
- (b) Prenatal care, except labor and delivery;
- (c) School-based services;
- (d) Personal care services;
- (e) Waiver services;
- (f) Nursing facility services, unless they are approved by the department's medical consultant; and

(g) Hospice services, unless they are approved by the department's medical consultant.

(8) The medical service limitations and exclusions described in subsection (7) also apply under the MN program.

(9) A person determined eligible for the AEM program is certified for three months. The number of three-month certification periods is not limited, but, the person must continue to meet eligibility criteria in subsection (2) and (4) of this section.

(10) A person is not eligible for the AEM program if that person entered the state specifically to obtain medical care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 07-07-024, § 388-438-0110, filed 3/9/07, effective 4/9/07; 06-04-047, § 388-438-0110, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 04-15-057, § 388-438-0110, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 1903 (v)(2)(c) of the Social Security Act, 03-24-058, § 388-438-0110, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and C.F.R. 436.128, 436.406(c) and 440.255, 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255, 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090, 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

**Chapter 388-440 WAC
EXCEPTION TO RULE**

WAC

388-440-0005 How am I informed of the decision on my request to the department for an exception to rule?

WAC 388-440-0005 How am I informed of the decision on my request to the department for an exception to rule? (1) You will receive the decision in writing within ten days when department staff:

- (a) Decides not to file the exception to rule request; or
- (b) Decides to approve or deny the exception to rule request.

(2) The notice includes information on how to file a complaint as specified in chapter 388-426 WAC.

(3) This section does not apply to notification requirements for exceptions to rules concerning noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090, 07-18-053, § 388-440-0005, filed 8/31/07, effective 10/1/07; 00-03-034, § 388-440-0005, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0005, filed 7/31/98, effective 9/1/98.]

**Chapter 388-444 WAC
FOOD STAMP EMPLOYMENT AND TRAINING**

WAC

388-444-0005 Food stamp employment and training (FS E&T) program—General requirements.
388-444-0025 Payments for FS E&T related expenses.

WAC 388-444-0005 Food stamp employment and training (FS E&T) program—General requirements. (1) To receive Basic Food some people must register for work

and participate in the food stamp employment and training (FS E&T) program.

(2) We determine if you must register for work and participate in FS E&T under WAC 388-444-0010:

(a) If we require you to register for work and participate in FS E&T you are nonexempt from FS E&T.

(b) If you meet one of the conditions under WAC 388-444-0015, you are exempt from FS E&T. If you are exempt, you may choose to receive services through the FS E&T program.

(3) If you are nonexempt from FS E&T requirements, we register you for work:

(a) When you apply for Basic Food benefits or are added to someone's assistance unit; and

(b) Every twelve months thereafter.

(4) If you are nonexempt, you must meet all the FS E&T program requirements in subsections (5) through (7) of this section. If you fail to meet the requirements without good cause, we disqualify you from receiving Basic Food benefits:

(a) We define good cause for not meeting FS E&T requirements under WAC 388-444-0050; and

(b) We disqualify nonexempt persons who fail to meet E&T requirements as described under WAC 388-444-0055.

(5) If you are nonexempt, you must:

(a) Report to us or your FS E&T service provider and participate as required;

(b) Provide information regarding your employment status and availability for work when we ask for it;

(c) Report to an employer when we refer you; and

(d) Accept a bona fide offer of suitable employment. We define unsuitable employment under WAC 388-444-0060.

(6) If you are nonexempt, you must participate in one or more of the following FS E&T activities:

(a) Job search;

(b) Paid or unpaid work;

(c) Training or work experience;

(d) General education development (GED) classes; or

(e) English as a second language (ESL) classes.

(7) If you must participate in WorkFirst under WAC 388-310-0200, you have certain requirements for the Food Stamp Employment and Training Program:

(a) Your FS E&T requirement is to fully participate in the WorkFirst activities approved in your Individual Responsibility Plan (IRP) under WAC 388-310-0500; and

(b) If your IRP includes unpaid community service or work experience, we use your TANF grant and the Basic Food benefits received by members of your TANF assistance unit to determine the maximum hours of unpaid work we include in your plan.

(8) Your FS E&T activities including paid or unpaid work **will not** exceed one hundred twenty hours a month whether you are exempt or nonexempt.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.7 and 273.25, 07-14-125, § 388-444-0005, filed 7/3/07, effective 8/3/07; 06-24-026, § 388-444-0005, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0025 Payments for FS E&T related expenses. (1) Some of a client's actual expenses needed to

participate in the FS E&T program may be paid by the department. Allowable expenses are:

- (a) Transportation related costs; and
 - (b) Dependent care costs for each dependent through twelve years of age.
- (2) Dependent care payments are not paid if:
- (a) The child is thirteen years of age or older unless the child is:
 - (i) Physically and/or mentally incapable of self-care; or
 - (ii) Under court order requiring adult supervision; or
 - (b) Any member in the food assistance unit provides the dependent care.
- (3) Dependent care payments paid by the department cannot be claimed as an expense and used in calculating the dependent care deduction as provided in WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.-090. 07-21-075, § 388-444-0025, filed 10/16/07, effective 11/16/07; 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

**Chapter 388-450 WAC
INCOME**

WAC

| | |
|--------------|--|
| 388-450-0185 | Does the department count all of my income to determine my eligibility and benefits for Basic Food? |
| 388-450-0190 | How does the department figure my shelter cost income deduction for Basic Food? |
| 388-450-0195 | Utility allowances for Basic Food programs. |
| 388-450-0215 | How does the department estimate my assistance unit's income to determine my eligibility and benefits? |

WAC 388-450-0185 Does the department count all of my income to determine my eligibility and benefits for Basic Food? We subtract the following amounts from your assistance unit's (AU's) countable income before we determine your Basic Food benefit amount:

- (1) A standard deduction based on the number of people in your AU under WAC 388-408-0035:

| Eligible and ineligible AU members | Standard deduction |
|---------------------------------------|--------------------|
| 1 | \$134 |
| 2 | \$134 |
| 3 | \$134 |
| 4 | \$143 |
| 5 | \$167 |
| 6 or more | \$191 |

- (2) Twenty percent of your AU's gross earned income (earned income deduction);
- (3) Your AU's expected monthly dependent care expense as described below:
 - (a) The dependent care must be needed for AU member to:
 - (i) Keep work, look for work, or accept work;
 - (ii) Attend training or education to prepare for employment; or
 - (iii) Meet employment and training requirements under chapter 388-444 WAC.
 - (b) We subtract allowable dependent care expenses that are payable to someone outside of your AU:

- (i) Up to two hundred dollars for each dependent under age two; and
- (ii) Up to one hundred seventy-five dollars for each dependent age two or older.
- (4) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled person in your AU as allowed under WAC 388-450-0200.
- (5) Legally obligated current or back child support paid to someone outside of your AU:
 - (a) For a person who is not in your AU; or
 - (b) For a person who is in your AU to cover a period of time when they were not living with you.
- (6) A portion of your shelter costs as described in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0185, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0185, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0185, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0185, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0185, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002. 02-22-044, § 388-450-0185, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 How does the department figure my shelter cost income deduction for Basic Food? The department calculates your shelter cost income deduction as follows:

- (1) First, we add up the amounts your assistance unit (AU) must pay each month for shelter. We do not count any overdue amounts, late fees, penalties or mortgage payments you make ahead of time as an allowable cost. We count the following expenses as an allowable shelter cost in the month the expense is due:
 - (a) Monthly rent, lease, and mortgage payments;
 - (b) Property taxes;
 - (c) Homeowner's association or condo fees;
 - (d) Homeowner's insurance for the building only;
 - (e) Utility allowance your AU is eligible for under WAC 388-450-0195;
 - (f) Out-of-pocket repairs for the home if it was substantially damaged or destroyed due to a natural disaster such as a fire or flood;
 - (g) Expense of a temporarily unoccupied home because of employment, training away from the home, illness, or abandonment caused by a natural disaster or casualty loss if your:
 - (i) AU intends to return to the home;
 - (ii) AU has current occupants who are not claiming the shelter costs for Basic Food purposes; and
 - (iii) AU's home is not being leased or rented during your AU's absence.
- (2) Second, we subtract all deductions your AU is eligible for under WAC 388-450-0185 (1) through (5) from your AU's gross income. The result is your AU's net income.

(3) Finally, we subtract one-half of your AU's net income from your AU's total shelter costs. The result is your excess shelter costs. Your AU's shelter cost deduction is the excess shelter costs:

(a) Up to a maximum of four hundred thirty-one dollars if no one in your AU is elderly or disabled; or

(b) The entire amount if an eligible person in your AU is elderly or disabled, even if the amount is over four hundred thirty-one dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0190, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0190, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0190, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0190, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-07-138, § 388-450-0190, filed 3/22/04, effective 5/1/04; 03-21-030, § 388-450-0190, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0190, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0190, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-06-030, § 388-450-0190, filed 3/2/01, effective 4/2/01; 99-16-024, § 388-450-0190, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Utility allowances for Basic Food programs. (1) For Basic Food, "utilities" include the following:

- (a) Heating or cooling fuel;
- (b) Electricity or gas;
- (c) Water or sewer;
- (d) Well or septic tank installation/maintenance;
- (e) Garbage/trash collection; and
- (f) Telephone service.

(2) The department uses the amounts below if you have utility costs separate from your rent or mortgage payment. We add your utility allowance to your rent or mortgage payment to determine your total shelter costs. We use total shelter costs to determine your Basic Food benefits.

(a) If you have heating or cooling costs, you get a standard utility allowance (SUA) that depends on your assistance unit's size.

| Assistance Unit (AU) Size | Utility Allowance |
|---------------------------|-------------------|
| 1 | \$328 |
| 2 | \$338 |
| 3 | \$348 |
| 4 | \$358 |
| 5 | \$368 |
| 6 or more | \$378 |

(b) If your AU does not qualify for the SUA and you have any two utility costs listed above, you get a limited utility allowance (LUA) of two hundred fifty-nine dollars.

(c) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of forty dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-450-0195, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-

450-0195, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-10-056, § 388-450-0195, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. § 273.9. 05-19-062, § 388-450-0195, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-09-087, § 388-450-0195, filed 4/19/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0195, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0195, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0195, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0195, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.510. 00-22-065, § 388-450-0195, filed 10/27/00, effective 11/1/00. Statutory Authority: RCW 74.04.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0215 How does the department estimate my assistance unit's income to determine my eligibility and benefits? (1) We decide if your assistance unit (AU) is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's gross monthly income and expenses. This is known as prospective budgeting.

(2) We use your current, past, and future circumstances for a representative estimate of your monthly income.

(3) We may need proof of your circumstances to ensure our estimate is reasonable. This may include documents, statements from other people, or other proof as explained in WAC 388-490-0005.

(4) We use one of two methods to estimate income:

(a) **Anticipating monthly income (AM):** With this method, we base the estimate on the actual income we expect your AU to receive in the month (see subsection (5)); and

(b) **Averaging income (CA):** With this method, we add the total income we expect your AU to receive for a period of time and divide by the number of months in the period (see subsection (6)).

(5) Anticipating monthly income: We must use the anticipating monthly method:

(a) For the month you apply for benefits unless:

(i) We are determining eligibility for children's medical programs as listed in WAC 388-505-0210 (3) through (6) or pregnancy medical as listed in WAC 388-462-0015. For children's and pregnancy medical we can use either method; or

(ii) You are paid less often than monthly (for example: you are paid quarterly or annually). If you are paid less often than monthly, we average your income for the month you apply. Section (6) explains how we average your income.

(b) When we estimate income for anyone in your AU, if you or anyone in your AU receive SSI-related medical benefits under chapter 388-475 WAC.

(c) When we must allocate income to someone who is receiving SSI-related medical benefits under chapter 388-475 WAC.

(d) When you are a destitute migrant or destitute seasonal farmworker under WAC 388-406-0021. In this situation, we must use anticipating monthly (AM) for all your AU's income.

(e) To budget SSI or social security benefits even if we average other sources of income your AU receives.

(6) Averaging income: When we average your income, we consider changes we expect for your AU's income. We determine a monthly amount of your income based on how often you are paid:

(a) If you are paid weekly, we multiply your expected income by 4.3;

(b) If you are paid every other week, we multiply your expected income by 2.15;

(c) In most cases if you receive your income other than weekly or every other week, we estimate your income over your certification period by:

(i) Adding the total income for representative period of time;

(ii) Dividing by the number of months in the timeframe; and

(iii) Using the result as a monthly average.

(d) If you receive your yearly income over less than a year because you are self employed or work under a contract, we average this income over the year unless you are:

(i) Paid on an hourly or piecework basis; or

(ii) A migrant or seasonal farmworker under WAC 388-406-0021.

(7) If we used the anticipating monthly income method for the month you applied for benefits, we may average your income for the rest of your certification period if we do not have to use this method for any other reason in section (5).

(8) If you report a change in your AU's income, and we expect the change to last through the end of the next month after you reported it, we update the estimate of your AU's income based on this change.

(9) If your actual income is different than the income we estimated, we don't make you repay an overpayment under chapter 388-410 WAC or increase your benefits unless you meet one of the following conditions:

(a) You provided incomplete or false information; or

(b) We made an error in calculating your benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-02-054, § 388-450-0215, filed 12/28/07, effective 2/1/08; 05-16-109, § 388-450-0215, filed 8/2/05, effective 10/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-052, § 388-450-0215, filed 3/1/04, effective 4/1/04; 03-21-029, § 388-450-0215, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0215, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0215, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

Chapter 388-473 WAC

ONGOING ADDITIONAL REQUIREMENTS

WAC

388-473-0040 Food for service animals as an ongoing additional requirement.

WAC 388-473-0040 Food for service animals as an ongoing additional requirement. (1) A "service animal" is an animal that is trained for the purpose of assisting or accommodating a person with a disability's sensory, mental, or physical disability.

(2) We authorize benefits for food for a service animal if we decide the animal is necessary for your health and safety and supports your ability to continue to live independently.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 49.60.040. 07-10-043, § 388-473-0040, filed 4/26/07, effective 5/27/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0040, filed 7/17/00, effective 9/1/00.]

Chapter 388-478 WAC

STANDARDS FOR PAYMENTS

WAC

388-478-0015 Need standards for cash assistance.
 388-478-0055 How much do I get from my state supplemental payments (SSP)?
 388-478-0060 What are the income limits and maximum benefit amounts for Basic Food?

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

| Assistance Unit Size | Need Standard |
|----------------------|---------------|
| 1 | \$1,060 |
| 2 | 1,341 |
| 3 | 1,655 |
| 4 | 1,953 |
| 5 | 2,251 |
| 6 | 2,549 |
| 7 | 2,947 |
| 8 | 3,261 |
| 9 | 3,576 |
| 10 or more | 3,890 |

(2) For assistance units with shelter provided at no cost:

| Assistance Unit Size | Need Standard |
|----------------------|---------------|
| 1 | \$566 |
| 2 | 717 |
| 3 | 885 |
| 4 | 1,044 |
| 5 | 1,203 |
| 6 | 1,362 |
| 7 | 1,575 |
| 8 | 1,743 |
| 9 | 1,911 |
| 10 or more | 2,079 |

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 07-24-033, § 388-478-0015, filed 11/30/07, effective 12/31/07; 07-06-066, § 388-478-0015, filed 3/5/07, effective 4/5/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-05-102, § 388-478-0015, filed 2/14/06, effective 3/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 05-22-077 and 05-23-012, § 388-478-0015, filed 10/31/05 and 11/4/05, effective 1/1/06; 05-01-074, § 388-478-0015, filed 12/9/04, effective 1/9/05. Statutory Authority: RCW 74.04.770, 74.04.050, 74.04.055, 74.04.057. 03-24-059, § 388-478-0015, filed 12/1/03, effective 1/1/04; 03-23-116, § 388-478-0015, filed 11/18/03, effective 12/19/03. Statutory Authority: RCW 74.08.090, 74.04.510, and 74.04.770. 02-23-029, § 388-478-0015, filed 11/12/02, effective 12/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200. 01-11-108, § 388-478-0015, filed 5/21/01, effective 7/1/01. Statutory Authority: RCW 74.04.200. 99-04-056, § 388-478-0015, filed 1/29/99, effective 3/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0055 How much do I get from my state supplemental payments (SSP)? (1) The SSP is a payment from the state for certain SSI eligible people (see WAC 388-474-0012).

If you converted to the federal SSI program from state assistance in January 1974, because you were aged, blind, or disabled, and have remained continuously eligible for SSI since January 1974, the department calls you a grandfathered client. Social Security calls you a mandatory income level (MIL) client.

A change in living situation, cost-of-living adjustment (COLA) or federal payment level (FPL) can affect a grandfathered (MIL) client. A grandfathered (MIL) client gets a federal SSI payment and a SSP payment, which totals the higher of one of the following:

(a) The state assistance standard set in December 1973, unless you lived in a medical institution at the time of conversion, plus the federal cost-of-living adjustments (COLA) since then; or

(b) The current payment standard.

(2) The monthly SSP rates for eligible persons under WAC 388-474-0012 and individuals residing in an institution are:

| | |
|---|------------------|
| SSP eligible persons | Monthly SSP Rate |
| Individual (aged 65 and older) | \$46.00 |
| Individual (blind as determined by SSA) | \$46.00 |
| Individual with an ineligible spouse | \$46.00 |

SSP eligible persons
Grandfathered (MIL)

Monthly SSP Rate
Varies by individual based on federal requirements.
Payments range between \$0.54 and \$199.77.

Medical institution
Individual

Monthly SSP Rate
\$25.45

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 07-22-022, § 388-478-0055, filed 10/26/07, effective 11/26/07; 06-16-071, § 388-478-0055, filed 7/28/06, effective 8/28/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090. 06-01-045, § 388-478-0055, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057, 74.08.090. 04-07-024, § 388-478-0055, filed 3/8/04, effective 4/8/04; 03-03-114, § 388-478-0055, filed 1/21/03, effective 2/23/03. Statutory Authority: RCW 74.08.090, 74.04.057. 01-19-024, § 388-478-0055, filed 9/12/01, effective 11/1/01; 01-08-015, § 388-478-0055, filed 3/23/01, effective 5/1/01. Statutory Authority: RCW 74.08.090. 00-20-054, § 388-478-0055, filed 9/29/00, effective 11/1/00. Statutory Authority: RCW 74.08.090 and 74.04.057. 00-11-130, § 388-478-0055, filed 5/22/00, effective 7/1/00; 99-18-063, § 388-478-0055, filed 8/30/99, effective 10/1/99. Statutory Authority: RCW 74.08.090 and 74.04.630. 99-04-103, § 388-478-0055, filed 2/3/99, effective 3/6/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1115.]

WAC 388-478-0060 What are the income limits and maximum benefit amounts for Basic Food? If your assistance unit (AU) meets all other eligibility requirements for Basic Food, your AU must have income at or below the limits in column B and C to get Basic Food, unless you meet one of the exceptions listed below. The maximum monthly food assistance benefit your AU could receive is listed in column D.

| EFFECTIVE 10-1-2007 | | | | | |
|-------------------------------|------------------------------|----------------------------|-------------------|-----------------------|--|
| Column A | Column B | Column C | Column D | Column E | |
| Number of Eligible AU Members | Maximum Gross Monthly Income | Maximum Net Monthly Income | Maximum Allotment | 165% of Poverty Level | |
| 1 | \$1,107 | \$851 | \$162 | \$1,404 | |
| 2 | 1,484 | 1,141 | 298 | 1,883 | |
| 3 | 1,861 | 1,431 | 426 | 2,361 | |
| 4 | 2,238 | 1,721 | 542 | 2,840 | |
| 5 | 2,615 | 2,011 | 643 | 3,318 | |
| 6 | 2,992 | 2,301 | 772 | 3,797 | |
| 7 | 3,369 | 2,591 | 853 | 4,275 | |
| 8 | 3,746 | 2,881 | 975 | 4,754 | |
| 9 | 4,123 | 3,171 | 1,097 | 5,233 | |
| 10 | 4,500 | 3,461 | 1,219 | 5,712 | |
| Each Additional Member | +377 | +290 | +122 | +479 | |

Exceptions:

(1) If your AU is categorically eligible as under WAC 388-414-0001, your AU does not have to meet the gross or net income standards in columns B and C. We do budget your AU's income to decide the amount of Basic Food your AU will receive.

(2) If your AU includes a member who is sixty years of age or older or has a disability, your income must be at or below the limit in column C only.

(3) If you are sixty years of age or older and cannot buy and cook your own meals because of a permanent disability, we will use column E to decide if you can be a separate AU.

(4) If your AU has zero income, your benefits are the maximum allotment in column D, based on the number of eligible members in your AU.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-478-0060, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-478-0060, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050,

74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-478-0060, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-478-0060, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-478-0060, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-21-050, § 388-478-0060, filed 10/14/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-478-0060, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.510, 74.08.090. 00-23-013, § 388-478-0060, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.04.510. 99-24-053, § 388-478-0060, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.510, 74.08.090. 99-05-074, § 388-478-0060, filed 2/17/99, effective 3/20/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0060, filed 7/31/98, effective 9/1/98.]

Chapter 388-492 WAC

WASHINGTON COMBINED APPLICATION PROJECT

WAC

| | |
|--------------|--|
| 388-492-0040 | Can I choose whether I get WASHCAP food benefits or Basic Food benefits? |
| 388-492-0070 | How are my WASHCAP food benefits calculated? |

WAC 388-492-0040 Can I choose whether I get WASHCAP food benefits or Basic Food benefits? You can choose to have Basic Food benefits instead of WASHCAP food benefits when:

- (1) Your out-of-pocket medical expenses are more than thirty-five dollars a month;
- (2) You chose to have Basic Food benefits instead of WASHCAP benefits prior to April 25, 2005; or
- (3) Your food benefits under Basic Food would be at least forty dollars more due to excess shelter costs under WAC 388-450-0190 (1)(a) through (e) or legally obligated child support payments.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 07-12-025, § 388-492-0040, filed 5/29/07, effective 6/29/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-492-0040, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-18-036, § 388-492-0040, filed 8/30/05, effective 10/1/05; 05-08-009, § 388-492-0040, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0040, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-492-0040, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 03-01-045, § 388-492-0040, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0040, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0040, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0070 How are my WASHCAP food benefits calculated? We calculate your food benefits as follows:

- (1) We begin with your gross income.
- (2) We subtract one hundred thirty-four dollars from your gross income to get your countable income.
- (3) We figure your shelter cost based on information we receive from Social Security Administration (SSA), unless you report a change as described under WAC 388-492-0080. If you pay:
 - (a) Two hundred seventy-five dollars or more a month for shelter, we use three hundred sixty-six dollars as your shelter cost; or

(b) Less than two hundred seventy-five dollars for shelter, we use one hundred seventy-six dollars as your shelter cost; and

(c) We add the current standard utility allowance under WAC 388-450-0195 to determine your total shelter cost.

(4) We figure your shelter deduction by subtracting one half of your countable income from your shelter cost.

(5) We figure your net income by subtracting your shelter deduction from your countable income and rounding the resulting figure up from fifty cents and down from forty-nine cents to the nearest whole dollar.

(6) We figure your WASHCAP food benefits (allotment) by:

(a) Multiplying your net income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the result from the maximum allotment under WAC 388-478-0060.

(c) If you are eligible for WASHCAP, you will get at least ten dollars in food benefits each month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-492-0070, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-492-0070, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-155, § 388-492-0070, filed 8/22/05, effective 10/1/05; 05-08-008, § 388-492-0070, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0070, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-492-0070, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 03-01-045, § 388-492-0070, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0070, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0070, filed 10/16/01, effective 12/1/01.]

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

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| 388-501-0070 | Healthcare coverage—Noncovered services. |
| 388-501-0100 | Subrogation. |

WAC 388-501-0070 Healthcare coverage—Noncovered services. (1) The department does not pay for any service, treatment, equipment, drug or supply not listed or referred to as a covered service in WAC 388-501-0060, regardless of medical necessity. Circumstances under which clients are responsible for payment of services are described in WAC 388-502-0160.

(2) This section does not apply to services provided under the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter 388-534 WAC.

(3) The department does not pay for any ancillary service(s) provided in association with a noncovered service.

(4) The following list of noncovered services is not intended to be exhaustive. Noncovered services include, but are not limited to:

(a) Any service specifically excluded by federal or state law;

(b) Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, naturopathy, and sanopractice;

- (c) Chiropractic care for adults;
 - (d) Cosmetic, reconstructive, or plastic surgery, and any related services and supplies, not specifically allowed under WAC 388-531-0100(4).
 - (e) Ear or other body piercing;
 - (f) Face lifts or other facial cosmetic enhancements;
 - (g) Gender reassignment surgery and any surgery related to transsexualism, gender identity disorders, and body dysmorphism, and related services, supplies, or procedures, including construction of internal or external genitalia, breast augmentation, or mammoplasty;
 - (h) Hair transplants, epilation (hair removal), and electrolysis;
 - (i) Fertility, infertility or sexual dysfunction testing, care, drugs, and treatment including but not limited to:
 - (i) Artificial insemination;
 - (ii) Donor ovum, sperm, or surrogate womb;
 - (iii) In vitro fertilization;
 - (iv) Penile implants;
 - (v) Reversal of sterilization; and
 - (vi) Sex therapy.
 - (j) Marital counseling;
 - (k) Motion analysis, athletic training evaluation, work hardening condition, high altitude simulation test, and health and behavior assessment;
 - (l) Nonmedical equipment;
 - (m) Penile implants;
 - (n) Prosthetic testicles;
 - (o) Psychiatric sleep therapy;
 - (p) Subcutaneous injection filling;
 - (q) Tattoo removal;
 - (r) Transport of Involuntary Treatment Act (ITA) clients to or from out-of-state treatment facilities, including those in bordering cities; and
 - (s) Vehicle purchase - new or used vehicle.
- (5) For a specific listing of noncovered services in the following service categories, refer to the accompanying WAC citation:
- (a) Ambulance transportation as described in WAC 388-546-0250;
 - (b) Dental services (for clients twenty-one years of age and younger) as described in chapter 388-535 WAC;
 - (c) Dental services (for clients twenty-one years of age and older) as described in chapter 388-535 WAC;
 - (d) Durable medical equipment as described in WAC 388-543-1300;
 - (e) Hearing care services as described in WAC 388-544-1400;
 - (f) Home health services as described in WAC 388-551-2130;
 - (g) Hospital services as described in WAC 388-550-1600;
 - (h) Physician-related services as described in WAC 388-531-0150;
 - (i) Prescription drugs as described in WAC 388-530-1150; and
 - (j) Vision care services as described in WAC 388-544-0475.
- (6) A client has a right to request an administrative hearing when a service is denied as noncovered. When the department denies all or part of a request for a noncovered ser-

vice(s) or equipment, the department sends the client and the provider written notice, within ten business days of the date the decision is made, that includes:

- (a) A statement of the action the department intends to take;
- (b) Reference to the specific WAC provision upon which the denial is based;
- (c) Sufficient detail to enable the recipient to:
 - (i) Learn why the department's action was taken; and
 - (ii) Prepare a response to the department's decision to classify the requested service as noncovered.
- (d) The specific factual basis for the intended action;
- (e) The following information:
 - (i) The client's administrative hearing rights;
 - (ii) Instructions on how to request the hearing;
 - (iii) Acknowledgement that a client may be represented at the hearing by legal counsel or other representative;
 - (iv) Upon the client's request, the name and address of the nearest legal services office;
 - (v) Instructions on how to request an exception to rule (ETR); and
 - (vi) Information regarding department-covered services, if any, as an alternative to the requested noncovered service.
- (7) A client can request an ETR as described in WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-04-036, § 388-501-0070, filed 1/29/07, effective 3/1/07.]

WAC 388-501-0100 Subrogation. (1) For the purpose of this section, "**liable third party**" means:

- (a) A person who commits or is guilty of a private or civil wrong doing or the insurer of that person, or both; and
 - (b) Any individual, entity or program that is or may be liable to pay for all or part of the expenditures for medical assistance furnished under the state plan. That liability must be based on any contract or insurance purchased by the client or any other person on behalf of the client.
- (2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any liable third party for medical expenses and/or assistance or residential care.
- (3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.
- (4) The department is not responsible to pay for medical care for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, the department may provide the medical care required as a result of an injury or illness to the client if both of the following apply:
- (a) The client is otherwise eligible for medical care; and
 - (b) No other liable third party has been identified at the time the claim is filed.
- (5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party or third party settlement or judgement as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.070 and RCW 74.09.180 and 74.09.185.
- (6) When a client obtains a settlement or judgement from a liable third party that includes compensation for medical or

residential care, the department must be reimbursed for the payments made for the benefit of the client as a result of the injury or illness suffered by the client.

(a) In the absence of evidence to the contrary as discussed below in subsection (6)(c), the department's rebuttable presumption is that the entire settlement or judgement, up to the amount of the medical damages suffered by the client, is intended to compensate the client for past medical expenses and will enforce its claim accordingly. The department is entitled to be reimbursed up to the full amount of medical assistance paid on behalf of the client for the medical dam-

ages related to the injury or illness suffered by the client less the department's proportionate share of attorney's fees and costs incurred in obtaining the settlement or judgement, as required by law.

(b) The department determines its net recovery by deducting its proportionate share of attorney's fees and costs from the gross medical damages amount according to the following formula, in the absence of a court-approved allocation of the medical damages or an agreement with the department establishing the allocation of medical damages:

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| (i) Gross settlement/judgement amount | \$ |
| (ii) Total amount of medical assistance paid | \$ |
| (iii) Department's percentage of attorney's fees and costs ((ii) divided by (i)) | % |
| (iv) Attorney's fees \$ + Legal costs \$ = | Total \$ |
| (v) Medicaid's pro rata share of fees and costs ((iv) multiplied by (iii)) | \$ |
| (vi) Medicaid's reimbursement ((ii) minus (v)) | \$ |

(c) If the client disagrees with the allocation as set forth in subsections (a) and (b) of this section:

(i) Prior to accepting or disbursing the settlement or judgement funds, the client or the client's legal representative must provide the department with documentation that a different allocation of medical damages was negotiated, proven at trial, or is being considered with the third party and/or their insurer or the client's insurance carrier in obtaining the settlement or judgement; and

(ii) If the client and the department are not able to come to an agreement as to the proper payment to be made to the department to satisfy the department's claim for reimbursement of the medical assistance paid on behalf of the client, the matter should be set before a court for an allocation hearing prior to the distribution of the settlement or judgement.

(d) If the injured client does not have legal representation in the personal injury action and does not incur attorney's fees or costs in obtaining the settlement or judgement, the department ensures that the client will receive not less than one third of the total settlement or judgement amount, or the balance of the settlement or judgement after the full amount of medical assistance is paid, whichever is greater, as satisfaction of all other damages suffered by the client;

(e) When the settlement or judgement obtained by the client exceeds the amount of the assistance paid, the department is entitled to recover up to the full amount of the medical assistance paid less the department's proportionate share of any attorney's fees and costs incurred in obtaining the settlement or judgement;

(f) When the amount of a settlement or judgement is less than or equal to the amount of the department's medical assistance payments:

(i) The department and the client and/or the client's legal representative must determine the appropriate allocation for medical damages; or

(ii) If the department and the client and/or the client's legal representative are unable to agree upon an allocation for medical damages, then a court must decide the amount the client must reimburse the department for medical assistance payments made on his or her behalf.

(g) Under no circumstances will the total amount that the department receives be less than one-third of the gross

amount of the settlement or judgement, unless the department agrees in writing to a lesser amount.

(7) Recovery according to the subrogation rights, assignment, or enforcement of the lien granted to the department is not reduced, prorated, or applied to only a portion of a judgment, award, or settlement. The secretary of the department or the secretary's designee must consent in writing to any discharge or compromise of any settlement or judgment of a lien created under RCW 42.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(8) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.08.090 and 74.09.185. 07-23-080 and 08-01-041, § 388-501-0100, filed 11/19/07 and 12/12/07, effective 12/1/08. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

**Chapter 388-502 WAC
ADMINISTRATION OF MEDICAL PROGRAMS—
PROVIDERS**

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-502-0240 Audits and the audit appeal process for contractors/providers. [Statutory Authority: RCW 74.08.090, 43.20B.-675. 00-23-014, § 388-502-0240, filed 11/3/00, effective 12/4/00.] Repealed by 07-10-022, filed 4/23/07, effective 6/1/07. Statutory Authority: RCW 74.09.200 and 74.08.090. Later promulgation, see chapter 388-502A WAC.

**Chapter 388-502A WAC
PROVIDER AUDITS AND APPEALS**

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|---------------|---------------------------------|
| WAC | |
| 388-502A-0100 | Purpose. |
| 388-502A-0200 | Definitions. |
| 388-502A-0300 | Authority to audit. |
| 388-502A-0400 | Audit objectives. |
| 388-502A-0500 | Audit methods and locations. |
| 388-502A-0600 | Notification of on-site audits. |
| 388-502A-0700 | Audit overview. |
| 388-502A-0800 | Auditing process. |

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| 388-502A-0900 | Audit sampling, extrapolation, and claim-by-claim review. |
| 388-502A-1000 | Provider audit—Draft report. |
| 388-502A-1100 | Provider audit—Dispute process. |
| 388-502A-1200 | Provider audit—Final report/appeal. |
| 388-502A-1300 | Audit outcomes. |

WAC 388-502A-0100 Purpose. (1) This chapter:

- (a) Defines the department's audit and appeal process for providers; and
- (b) Includes, but is not limited to, actions the department may take to ensure provider payments for covered services, supplies, or equipment:
 - (i) Are made in accordance with federal and state statutes and regulations; and
 - (ii) Comply with provider billing instructions, published memoranda, and fee schedules. For provider reimbursement rate appeals, see WAC 388-502-0220 and for hospital reports and audits, see WAC 388-550-5700.
- (2) This chapter applies to all providers except:
 - (a) Nursing homes as described in chapters 388-96, 388-97, and 388-98 WAC; and
 - (b) Managed care organizations as described in chapter 388-538 WAC.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0100, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0200 Definitions. Unless otherwise specified, the following definitions and those found in WAC 388-500-0005, apply to this chapter:

"Audit period"—The time period the department selects to review a provider's records. This time period is indicated in the audit report.

"Chargemaster"—A list of all goods and services and the prices the provider charges for each of those goods and services.

"Extrapolation"—The methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of an audited sample to the universe from which the sample was drawn.

"Medical assistance"—For purposes of this chapter, the common phrase used to describe all medical programs available through the department.

"Overpayment"—Any payment or benefit to a client or to a vendor in excess of what is entitled by law, rule or contract, including amounts in dispute, as defined in RCW 43.20B.010.

"Record"—Documentation maintained by a health services provider to show the details of the providing of services or products to a medical assistance client. See also WAC 388-502-0020, general provider requirements.

"Sample"—A selection of claims reviewed under a defined audit process.

"Universe"—A defined population of claims submitted by a provider for payment during a specific time period.

"Usual and customary charge"—The rate providers must bill the department for a certain service or equipment. This rate may not exceed:

- (1) The established charge billed to the general public for the same services; or
- (2) If the general public is not served, the established rate normally offered to other payers for the same services.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0200, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0300 Authority to audit. (1) Chapter 74.09 RCW authorizes the department to conduct audits, including reaudits, and to enforce its regulations and policies for all providers.

(2) The department conducts audits on a routine basis and as necessary. Audits can be conducted prior to, or following, payment of services, supplies, or equipment.

(3) The department may also conduct an audit as a result of:

- (a) Complaints/allegations;
- (b) Actions taken by the Centers for Medicare and Medicaid Services or the department regarding Medicare or medical assistance; or
- (c) Actions taken by the department of health.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0300, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0400 Audit objectives. A department audit has the following objectives:

(1) To determine if services billed and paid under the state's medical assistance and medical care service programs were:

- (a) Provided to an eligible client;
- (b) Medically necessary;
- (c) Provided at the appropriate level of care;
- (d) Appropriately documented; and
- (e) In accordance with WAC 388-502A-0100(1).

(2) To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations;

(3) To provide a mechanism for data gathering which can be used to modify the state's medical assistance and medical care service programs policies and procedures;

(4) To determine if the services provided meet the community standard of care; and

(5) To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the audit period.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0400, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0500 Audit methods and locations.

The department selects the appropriate method of conducting the audit including, but not limited to, the following:

- (1) On-site audits, conducted on the provider's premises;
- (2) Desk audits, conducted at the department's offices; or
- (3) A combination of an on-site and a desk audit.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0500, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0600 Notification of on-site audits.

(1) The department sends written notice of a scheduled on-site audit as follows:

- (a) Thirty calendar days in advance for hospitals according to RCW 70.41.045; and
 - (b) Ten business days in advance for all other providers.
- (2) Exceptions to the written notice in subsection (1) of this section include, but are not limited to:

(a) Providers who are suspected of fraudulent or abusive practices;

(b) When the department has reason to believe that a provider's action endangers the health and safety of one or more clients; or

(c) A third-party liability compliance audit.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0600, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0700 Audit overview. (1) The following may be included in the department audit:

(a) An examination of provider medical and financial records;

(b) A draft audit report, which contains findings and directives;

(c) A dispute process as described in WAC 388-502A-1100, unless a condition in subsection (4) of this section or a condition in WAC 388-502A-1100(8) applies; and

(d) A final audit report.

(2) Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Pursuant to WAC 388-502-0020, providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client;

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; and

(c) Make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. Refer to WAC 388-502-0020 for additional provider requirements.

(3) A health care provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

(4) If a provider fails to participate or comply with the department's audit process or unduly delays the department's audit process, the department considers the provider's actions or lack thereof, as abandonment of the audit.

(5) If the department suspects a provider of fraud, abusive practices, audit abandonment, or presents a risk of imminent danger to clients, the department may take one or more of the actions listed below:

(a) Immediately issue a final report;

(b) Terminate the core provider agreement;

(c) Issue a subpoena for the provider's records pursuant to RCW 43.20A.605; or

(d) Refer the provider to the appropriate prosecuting authority.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0700, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0800 Auditing process. (1) The department inspects provider records for objective data consistent with the purpose defined under WAC 388-502A-0100(1). The department may require a provider to furnish original records for the department to review.

(2) The department may assess an overpayment for medical services and terminate the core provider agreement if a provider fails to retain adequate documentation for services billed to the department.

(3) As part of the audit:

(a) The department may examine provider financial records, client medical records, employee records, provider appointment books, and any other applicable records that are related to the services billed to the department. The examination may:

(i) Verify usual and customary charges and payables including receivable accounts;

(ii) Verify third-party liability;

(iii) Compare clinical and fiscal records to each claim; and

(iv) Compare Medicaid charges to other insured or private pay patient charges to determine that the amount billed to the department is not more than the usual and customary charge documented in the provider's chargemaster.

(b) The department's procedures for auditing providers may include:

(i) Use of random sampling;

(ii) Extrapolation of principal and interest;

(iii) Conducting a claim audit;

(iv) Interviews with clients, providers, and/or their employees;

(v) Investigating complaints or allegations;

(vi) Investigating actions taken regarding Medicare or medical assistance; and

(vii) Investigating actions taken by the health profession's quality assurance commissions with the department of health.

(4) Per RCW 43.20A.605, the department may issue a subpoena for records from the provider or a third party including taking depositions or testimony under oath.

(5) When possible, the department works with the provider to minimize inconvenience and disruption of health care delivery during the audit.

(6) The department does not reimburse a provider's administrative fees, such as copying fees, for records requested during an audit.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0800, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-0900 Audit sampling, extrapolation, and claim-by-claim review. (1) The department's procedures for auditing providers may include, but are not limited to, the following:

(a) The use of random sampling and extrapolation; and/or

(b) A claim-by-claim based review.

(2) The department's sample sizes are sufficient to ensure a minimum of ninety-five percent confidence level.

(a) When calculating the amount to be recovered, the department totals all overpayments and underpayments reflected in the sample and may extrapolate to the universe from which the sample was drawn.

(b) When the department uses the results of an audit sample to extrapolate the amount to be recovered, the provider may request a description of all of the following:

(i) The universe from which the department drew the sample;

(ii) The sample size and method that the department used to select the sample; and

(iii) The formulas and calculation procedures the department used to determine the amount of the overpayment.

(c) If a provider rebills a claim(s) for an adjustment and that claim(s) is part of the audit universe, the department does not remove the original paid claim(s) amount from the audit universe.

(3) When a claim-by-claim audit is conducted, specific claims are selected from the universe and audit overpayments are not extrapolated.

(4) The department recovers overpayments identified in the final audit report.

(5) The department does not consider nonbilled or zero paid services or supplies when calculating underpayments or overpayments.

(6) The department considers undocumented services to be program overpayments.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0900, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-1000 Provider audit—Draft report.

(1) Upon completion of the examination of records, the department notifies the provider of missing files or records that are necessary to complete the audit. The department allows the provider thirty calendar days from the date of notification to locate and provide those records needed to complete an audit.

(2) After the department completes its review of the provider's records, the department issues a draft report.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1000, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-1100 Provider audit—Dispute process.

(1) A provider may dispute the draft audit findings by submitting a written request within thirty calendar days of receipt of the draft report. The provider must:

(a) Specify which finding(s) the provider is contesting;

(b) Supply documentation to support the provider's position; and

(c) Indicate whether a dispute conference is requested.

(2) The department acknowledges and responds in writing to providers' requests for a dispute conference and to each disputed finding.

(3) In accordance with WAC 388-502A-0700 (4) and (5), the department may decline a provider's dispute request.

(4) The provider must schedule the dispute conference with the department within sixty calendar days from the day the provider receives the department's written acceptance of the request for a dispute conference.

(5) The provider requesting the dispute conference and the appropriate department representatives must attend the dispute conference.

(6) If the department and the provider reach an agreement during the dispute conference process, the department issues the final audit report.

(7) If the department and the provider cannot reach an agreement during the dispute process, and the provider has had the opportunity to raise all concerns related to the audit

findings, the department closes the dispute process and issues a final audit report.

(8) In addition to the circumstances in WAC 388-502A-0600(2), the department may also issue a final audit report without the dispute process described in this section when the provider:

(a) Transfers ownership of the business;

(b) Ceases doing business in Washington;

(c) Files for bankruptcy;

(d) Transfers business or personal assets available to the audited entity at the time of the initial audit; or

(e) Abandons the dispute process by failing to participate in the process.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1100, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-1200 Provider audit—Final report/appeal.

(1) After the department issues the final audit report, the provider has twenty-eight calendar days from the date of the report to appeal the overpayment. Audit appeal hearings are governed by RCW 43.20B.675.

(2) The request for an audit appeal hearing must:

(a) Be in writing;

(b) State the basis for contesting the final audit report;

(c) Include a copy of the department's final audit report;

(d) Be received by the department within twenty-eight calendar days of the provider's receipt of the notice of overpayment;

(e) Be served on the department in a manner which provides proof of receipt as described in WAC 388-02-0050; and

(f) Be sent to:

DSHS Office of Financial Recovery

P.O. Box 9501

Olympia, WA 98507-9501

(3) The burden of proving compliance with applicable federal and state statutes and regulations, provider billing instructions, published memoranda, and fee schedules rests with the provider at the audit appeal hearing.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1200, filed 4/23/07, effective 6/1/07.]

WAC 388-502A-1300 Audit outcomes. (1) Based on audit findings, the department may:

(a) Request repayment, including interest on the amount of excess benefits or payments, per RCW 43.20B.695; and

(b) Assess civil penalties per chapter 74.09 RCW. The amount of civil penalties may not exceed three times the amount of excess benefits or payments the provider received.

(2) When the department imposes a civil penalty or terminates a provider's core provider agreement the department gives written notice of the action taken to the appropriate licensing agency, disciplinary commission, or other entity requiring a report.

(3) When an audit shows that a provider has not complied with the regulations and policies of the medical assistance or the medical care service program(s), the department may refer that provider to the appropriate disciplinary commission.

(4) When the department finds evidence of or has reason to suspect fraud, the provider is referred to the appropriate prosecuting authority for possible criminal action.

[Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1300, filed 4/23/07, effective 6/1/07.]

Chapter 388-503 WAC

PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

388-503-0505 General eligibility requirements for medical programs.

WAC 388-503-0505 General eligibility requirements for medical programs. (1) Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.

(2) Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

(3) Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program is as follows:

(a) Verification of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and

(b) Residence in Washington state (chapter 388-468 WAC); and

(c) Citizenship or immigration status in the United States (chapter 388-424 WAC); and

(d) Possession of a valid Social Security account number (chapter 388-476 WAC); and

(e) Assignment of medical support rights to the state of Washington (WAC 388-505-0540); and

(f) Cooperation in securing medical support (chapter 388-422 WAC); and

(g) Application for Medicare and enrollment into Medicare's prescription drug program if:

(i) It is likely that the individual is entitled to Medicare; and

(ii) The state has authority to pay Medicare cost sharing as described in chapter 388-517 WAC.

(h) Countable resources within program limits (chapters 388-470 and 388-478 WAC); and

(i) Countable income within program limits (chapters 388-450 and 388-478 WAC).

(4) In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

(5) Persons living in a public institution, including a correctional facility, are not eligible for the department's medical coverage programs. For a person under age twenty or over age sixty-five who is a patient in an institution for mental disease see WAC 388-513-1315(13) for exception.

(6) Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage continued while their eligibility for other medical programs is redetermined.

This continuation of medical coverage is described in chapter 388-434 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-530, 42 U.S.C., Section 1396a. 07-21-005, § 388-503-0505, filed 10/4/07, effective 11/4/07. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 1st sp.s. c 25. 04-07-141, § 388-503-0505, filed 3/22/04, effective 4/22/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-503-0505, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0505, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0110, 388-503-0305 and 388-505-0501.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

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|--------------|---|
| 388-513-1315 | Eligibility for long-term care (institutional, waiver, and hospice) services. |
| 388-513-1325 | Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). |
| 388-513-1330 | Determining available income for legally married couples for long-term care (LTC) services. |
| 388-513-1350 | Defining the resource standard and determining resource eligibility for long-term care (LTC) services. |
| 388-513-1363 | Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. |
| 388-513-1367 | Hardship waivers for long-term care (LTC) services. |
| 388-513-1380 | Determining a client's financial participation in the cost of care for long-term care (LTC) services. |
| 388-513-1395 | Determining eligibility for institutional or hospice services for individuals living in a medical institution under the medically needy (MN) program. |

WAC 388-513-1315 Eligibility for long-term care (institutional, waiver, and hospice) services. This section describes how the department determines a client's eligibility for institutional, waiver, or hospice services under the categorically needy (CN) program and institutional or hospice services in a medical institution under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the alien emergency medical programs described in subsection (11).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320;

(c) Meet functional eligibility described in chapter 388-106 WAC for waiver and nursing facility coverage; and

(d) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366.

(2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-475-0050 (1), (2) and (3) and meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (8)(a) that does not exceed the special income level (SIL); and

(ii) Countable resources described in subsection (7) that do not exceed the resource standard described in WAC 388-513-1350(1), unless subsection (4) applies; or

(b) Be approved and receiving the general assistance expedited Medicaid disability (GA-X) described in WAC 388-505-0110(6); or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0230; or

(d) Be eligible for the temporary assistance for needy families (TANF) program as described in WAC 388-505-0220.

(3) The department allows a client to have countable resources in excess of the standard described in WAC 388-513-1350 when meeting the conditions of reducing excess resources described in WAC 388-513-1350.

(4) To be eligible for waiver services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPEs, New Freedom, PACE, MMIP and WMIP services; or

(b) WAC 388-515-1510 for DDD waivers; or

(c) WAC 388-515-1540 for the medically needy residential waiver (MNRW); or

(d) WAC 388-515-1550 for the medically needy in-home waiver (MNIW).

(5) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 388-551 WAC; and

(b) Be eligible for a noninstitutional categorically needy program (CN-P) if not residing in a medical institution thirty days or more; or

(c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 (SSI related clients with income over the MNIL and at or below the 300 percent of the FBR or clients with a community spouse); or

(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(e) Reside in a state contracted and licensed alternate living facility and not on waiver services and receives medical assistance described in WAC 388-513-1305 as they are paying the facility privately.

(f) Be eligible for institutional CN if residing in a medical institution thirty days or more (use institutional rules for eligibility when in a medical institution thirty days or more).

(6) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for MN children's medical program described in WAC 388-505-0230; or

(b) Related to the SSI program as described in WAC 388-478-0050(1) and meet all requirements described in WAC 388-513-1395; or

(c) Eligible for the MN SSI related program described in WAC 388-475-0150 for hospice clients residing in a home setting; or

(d) Eligible for the MN SSI related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.

(e) Be eligible for institutional MN if residing in a medical institution thirty days or more (use institutional rules for eligibility when in a medical institution thirty days or more).

(7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resource eligibility and standards described in WAC 388-513-1350; and

(b) Evaluates the transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366.

(8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(9) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waiver services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395(6) for:

(a) Institutional services in a medical facility; or

(b) Hospice services in a medical facility.

(11) The department determines eligibility for nursing facility and hospice services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other requirements for such services but does not meet citizenship requirements. Nursing facility and hospice services under the AEM program must be preapproved by the department's medical consultant.

(12) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (9) through (11).

(13) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old at application and approval; or

(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or

(d) Is at least sixty-five years old.

(14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(15) The department considers the parents' income and resources available for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(16) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320.

(17) The department determines a client's participation in the cost of care for LTC services as described in WAC 388-513-1380 and 388-515-1505 for long-term care services under COPES, New Freedom, PACE, MMIP and WMIP or WAC 388-515-1510 for DDD waivers.

(18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of Medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505. Groups deemed to be receiving SSI and for Medicaid purposes are eligible to receive CN-P Medicaid. These groups are described in WAC 388-475-0880.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.39.010, 07-19-129, § 388-513-1315, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1315, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 71A.12-030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276, 04-18-054, § 388-513-1315, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500, 99-06-045, § 388-513-1315, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005, 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090, 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48, 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). This section describes income the department considers available when determining an SSI-related single client's eligibility for LTC services (institutional, waiver or hospice).

(1) Refer to WAC 388-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for SSI-related LTC services:

- (a) WAC 388-475-0600 Definition of income;
- (b) WAC 388-475-0650 Available income;
- (c) WAC 388-475-0700 Income eligibility;
- (d) WAC 388-475-0750 Countable unearned income;
- (e) WAC 388-475-0840(3) Self employment income-allowable expenses;
- (f) WAC 388-513-1315(16), Eligibility for long-term care (institutional, waiver, and hospice) services; and
- (g) WAC 388-450-0155, 388-450-0156 and 388-450-0160 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 07-14-087, § 388-513-1325, filed 6/29/07, effective 7/30/07. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

- (a) WAC 388-475-0600 Definition of income SSI-related medical;
- (b) WAC 388-475-0650 Available income;
- (c) WAC 388-475-7000 Income eligibility;
- (d) WAC 388-475-0750 Countable unearned income;
- (e) WAC 388-475-0840(3) Self employment income-allowance expenses;
- (f) WAC 388-506-0620, SSI-related medical clients; and
- (g) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waiver, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

- (a) Income received in the client's name;
- (b) Income paid to a representative on the client's behalf;
- (c) One-half of the income received in the names of both spouses; and
- (d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

- (a) Separate or community income received in the name of the community spouse; and
- (b) Income established as unavailable through a fair hearing.

(4) For the determination of eligibility only, if available income described in subsections (2)(a) through (d) minus income exclusions described in WAC 388-513-1340 exceeds the special income level (SIL), then:

- (a) The department follows community property law when determining ownership of income;
- (b) Presumes all income received after marriage by either or both spouses to be community income; and
- (c) Considers one-half of all community income available to the institutionalized client.

(5) If both spouses are either applying or approved for LTC services, then:

- (a) The department allocates one-half of all community income described in subsection (4) to each spouse; and
- (b) Adds the separate income of each spouse respectively to determine available income for each of them.

(6) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(7) The department considers income not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the income to:

- (a) The spouse; or
- (b) A trust for the benefit of the spouse.

(8) The department evaluates the transfer of a resource described in subsection (6) according to WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366 to determine whether a penalty period of ineligibility is required.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, and 2005 federal Deficit Reduction Act (DRA), Public Law 109-171. 07-17-152, § 388-513-1330, filed 8/21/07, effective 10/1/07. Statutory Authority: RCW 74.08.090. 06-07-077, § 388-513-1330, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.-585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1330, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (8) through (11) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (3) of this section applies.

(2) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(3) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(4) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the department applies (1)(b) of this section for a couple.

(5) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(6) The department applies the following rules when determining available resources for LTC services:

(a) WAC 388-475-0300, Resource eligibility;

(b) WAC 388-475-0250, How to determine who owns a resource; and

(c) WAC 388-470-0060(6), Resources of an alien's sponsor.

(7) For LTC services the department determines a client's countable resources as follows:

(a) The department determines countable resources for SSI-related clients as described in WAC 388-475-0350 through 388-475-0550 and resources excluded by federal law with the exception of:

(i) WAC 388-475-0550(16);

(ii) WAC 388-475-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) Vehicles not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For a SSI-related client, the department adds together the countable resources of both spouses if subsections (2), (5) and (8)(a) or (b) apply, but not if subsection (3) or (4) apply.

(d) For an SSI-related client, excess resources are reduced:

(i) In an amount equal to incurred medical expenses such as:

(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and Medicare;

(B) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan;

(C) Necessary medical care covered under the state's Medicaid plan incurred prior to Medicaid eligibility.

(ii) As long as the incurred medical expenses:

(A) Are not subject to third-party payment or reimbursement;

(B) Have not been used to satisfy a previous spend down liability;

(C) Have not previously been used to reduce excess resources;

(D) Have not been used to reduce client responsibility toward cost of care;

(E) Were not incurred during a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and

(F) Are amounts for which the client remains liable.

(e) Expenses not allowed to reduce excess resources or participation in personal care:

(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or boarding home is not a medical expense.

(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.

(f) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross income must be at or below the special income level (SIL), 300% of the FBR.

(B) In a medical institution, excess resources and income must be under the state medicaid rate.

(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to nonexcluded income, the combined total is less than the:

(A) Private medical institution rate plus the amount of recurring medical expenses for institutional services; or

(B) Private hospice rate plus the amount of recurring medical expenses, for hospice services in a medical institution.

(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(8) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, the department adds together one-half the total amount of countable resources held in the name of:

- (i) The institutionalized spouse; or
- (ii) Both spouses.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

- (i) Either spouse; or
- (ii) Both spouses.

(9) If subsection (8)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. The maximum allocation amount is ninety-nine thousand five hundred forty dollars effective January 1, 2006. Effective January 1, 2007, the maximum allocation is one hundred and one thousand six hundred and forty dollars. (This standard increases annually on January 1st based on the consumer price index); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the beginning of the current period of institutional status, up to the amount described in subsection (9)(a) of this section; or

(ii) The state spousal resource standard of forty-five thousand one hundred four dollars effective July 1, 2007 (this standard increases every odd year on July 1st). This increase

is based on the consumer price index published by the federal bureau of labor statistics.

(10) The amount of the spousal share described in (9)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(11) The amount of allocated resources described in subsection (9) of this section can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in a fair hearing described in chapter 388-02 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(12) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (5) or (13)(a), (b), or (c) of this section applies.

(13) A redetermination of the couple's resources as described in subsection (7) is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a), if subsection (8)(b) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (9) or (11) to the community spouse or to another person for the sole benefit of the community spouse as described in WAC 388-513-1365(4) by either:

(i) The first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, and 74.09.530. 07-19-128, § 388-513-1350, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) Public Law 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 07-01-073, § 388-513-1350, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1350, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). 04-04-072, § 388-513-1350, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112,

1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1363 Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

- Refer to WAC 388-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003 and before May 1, 2006.

- Refer to WAC 388-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

(2) The department does not apply a penalty period to transfers meeting the following conditions:

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing

evidence must be presented regarding the specific purpose of the transfer.

(iii) All assets transferred for less than fair market value have been returned to the client.

(iv) The denial of eligibility would result in an undue hardship as described in WAC 388-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-475-0050 (1)(c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the individual to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 388-475-0050 (1)(c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 388-475-0050 (1)(c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(f), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (8)(a) becomes an available resource as of the first day of the following month.

(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsections (7)(a), (b), and (c).

(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;

(a) We divide the penalty between the two spouses.

(b) If one spouse is no longer subject to a penalty (e.g. the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, and 2005 Federal Deficit Reduction Act (DRA), Public Law 109-171. 07-17-152, § 388-513-1363, filed 8/21/07, effective 10/1/07.]

WAC 388-513-1367 Hardship waivers for long-term care (LTC) services. Clients who are denied or terminated from LTC services due to a transfer of asset penalty (described in WAC 388-513-1363, 388-513-1364 and 388-513-1365), or having excess home equity (described in WAC 388-513-1350) may apply for an undue hardship waiver. Notice of the right to apply for an undue hardship waiver will be given whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

- Defines undue hardship;
- Specifies the approval criteria for an undue hardship request;
- Establishes the process the department follows for determining undue hardship; and
- Establishes the appeal process for a client whose request for an undue hardship is denied.

(1) When does undue hardship exist?

(a) Undue hardship may exist:

(i) When a client who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian or attorney-in-fact, has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period; and

(ii) The client provides sufficient documentation to support their efforts to recover the assets or income; or

(iii) The client is unable to access home equity in excess of five hundred thousand dollars due to a lien or legal impediment; and

(iv) When, without LTC benefits, the client is unable to obtain:

(A) Medical care to the extent that his or her health or life is endangered; or

(B) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(2) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a client or restricts their lifestyle but does not seriously deprive him or her as defined in subsection (1)(a)(iii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the client; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the client.

(d) Undue hardship may exist under (b) and (c) if DSHS has found evidence of financial exploitation.

(3) How is an undue hardship waiver requested?

(a) An undue hardship waiver may be requested by:

(i) The client;

(ii) The client's spouse;

(iii) The client's authorized representative;

(iv) The client's power of attorney; or

(v) With the consent of the client or their guardian, a medical institution, as defined in WAC 388-500-0005, in which an institutionalized client resides.

(b) Request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a client, then the client's name, address and telephone number must be included;

(iv) Be made within thirty days of the date of denial or termination of LTC services; and

(v) Returned to the originating address on the denial/termination letter.

(4) What if additional information is needed to determine a hardship waiver?

(a) A written notice to the client is sent requesting additional information within fifteen days of the request for an undue hardship waiver. Additional time to provide the information can be requested by the client.

(5) What happens if my hardship waiver is approved?

(a) The department sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a client's situation that led to the approval of a hardship must be reported to the department by the tenth of the month following the change per WAC 388-418-0007.

(6) What happens if my hardship waiver is denied?

(a) The department sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice will have instructions on how to request an administrative hearing. The department must

receive an administrative hearing request within ninety days of the date of the adverse action or denial.

(7) What statute or rules govern administrative hearings?

(a) An administrative hearing held under this section is governed by chapters 34.05 RCW and chapter 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(8) Can the department revoke an approved undue hardship waiver?

(a) The department may revoke approval of an undue hardship waiver if any of the following occur:

(i) A client, or his or her authorized representative, fails to provide timely information and/or resource verifications as it applies to the hardship waiver when requested by the department per WAC 388-490-0005 and 388-418-0007;

(ii) The lien or legal impediment that restricted access to home equity in excess of five hundred thousand dollars is removed; or

(iii) Circumstances for which the undue hardship was approved have changed.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, Section 1917 (c)(2)(D) of the Social Security Act (42 U.S.C. 1396p (c)(2)(D), and Section 6011(d) of the federal Deficit Reduction Act of 2005. 07-17-005, § 388-513-1367, filed 8/2/07, effective 9/2/07.]

WAC 388-513-1380 Determining a client's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the department allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The department applies rules described in WAC 388-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.

(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with income under the Medicaid special income level (SIL) (300% of the federal benefit rate (FBR)), if the client is not otherwise eligible for another non-institutional categorically needy Medicaid program. (Note: For hospice applicants with income over the Medicaid SIL, medically needy Medicaid rules apply.)

(4) The department allocates nonexcluded income in the following order and the combined total of (4)(a), (b), (c), and (d) cannot exceed the medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) One hundred sixty dollars for a client living in a state veterans' home;

(ii) Ninety dollars for a veteran or a veteran's surviving spouse, who receives the ninety dollar VA improved pension and does not live in a state veterans' home; or

(iii) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving general assistance.

(iv) Effective July 1, 2007, fifty-five dollars and forty-five cents for all other clients in a medical institution.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the Supplemental Security Income (SSI) program as described in WAC 388-503-0510(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(5) The department allocates nonexcluded income after deducting amounts described in subsection (4) in the following order:

(a) Income garnished for child support or withheld according to a child support order in the month of garnishment (for current and back support):

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2007, two thousand five hundred forty-one dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance is increased each January based on the consumer price index increase (from September to September, <http://www.bls.gov/cpi/>). The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse:

(A) In an amount equal to one-third of one hundred fifty percent of the two person federal poverty level less the dependent family member's income. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>).

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the institutional client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income exemption.

(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (6)(b) less the standard shelter allocation under subsection (6)(a). For the purposes of this rule:

(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance for four persons, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(7) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearing officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(8) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 2006 c 372, 07-19-126, § 388-513-1380, filed 9/19/07, effective 10/20/07; 07-01-072, § 388-513-1380, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530 and 2005 c 518 § 207 and Sec. 1924 Social Security Act (42 U.S.C. 1396r-5). 06-07-144, § 388-513-1380, filed 3/21/06, effective 4/21/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1380, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). 04-04-072, § 388-513-1380, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). 01-18-055, § 388-513-1380, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924(g) of the Social Security Act. 00-17-058, § 388-513-1380, filed 8/9/00, effective 9/9/00. Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015). 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 USC 396r-5). 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory

Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

WAC 388-513-1395 Determining eligibility for institutional or hospice services for individuals living in a medical institution under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.

(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5). In addition, a client must meet program requirements described in WAC 388-513-1315; and

(a) Be an SSI-related client with countable income as described in subsection (4)(a) that is more than the special income level (SIL); or

(b) Be a child not described in subsection (1)(a) with countable income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

(2) For an SSI-related client, excess resources can be reduced by medical expenses as described in WAC 388-513-1350.

(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:

(a) For an SSI-related client, the department determines countable resources per WAC 388-513-1350.

(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.

(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:

(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:

(i) Excluding income described in WAC 388-513-1340;

(ii) Disregarding income described in WAC 388-513-1345; and

(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.

(b) For a child not described in subsection (4)(a), the department:

(i) Follows the income rules described in WAC 388-505-0210 for the children's medical program; and

(ii) Subtracts the medical expenses described in subsection (4).

(5) If the combined total of a client's countable income, when added to countable resources in excess of the standard described in WAC 388-513-1350(1), is less than the department-contracted rate plus the amount of recurring medical expenses, the client:

(a) Is eligible for institutional or hospice services in a medical institution, and noninstitutional medical assistance;

(b) Is approved for twelve months; and

(c) Participates in the cost of care as described in WAC 388-513-1380.

(6) If the combined total of a client's countable income, which when added to countable resources in excess of the standard described in WAC 388-513-1350(1) is less than the private nursing facility rate plus the amount of recurring medical expenses, but more than the department contracted rate, the client:

(a) Is eligible for nursing facility care only and is approved for a three or six month base period as described in chapter 388-519 WAC; and

(i) Pays the nursing home at the current state rate;

(ii) Participates in the cost of care as described in WAC 388-513-1380; and

(iii) Is not eligible for medical assistance or hospice services unless the requirements in (6)(b) or (c) are met.

(b) Is approved for medical assistance for a three or six month base period as described in chapter 388-519 WAC, if:

(i) No income and resources remain after the post eligibility treatment of income process described in WAC 388-513-1380.

(ii) Medicaid certification is approved beginning with the first day of the base period.

(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income and resources remaining after the post eligibility treatment of income process described in WAC 388-513-1380.

(i) This process is known as spenddown and is described in WAC 388-519-0100.

(ii) Medicaid certification is approved on the day the spenddown is met.

(7) If the combined total of a client's nonexcluded income, which when added to nonexcluded resources is above the facility monthly private rate:

(a) The client is ineligible using institutional rules.

(b) Eligibility is considered under a noninstitutional medical assistance program described in chapter 388-416 and 388-519 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.39.010. 07-19-129, § 388-513-1395, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.-585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

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| 388-515-1505 | Financial eligibility requirements for long-term care services under COPES, New Freedom, PACE, MMIP, and WMIP. |
| 388-515-1550 | Medically needy in-home waiver (MNIW) effective May 1, 2004. |

WAC 388-515-1505 Financial eligibility requirements for long-term care services under COPES, New Freedom, PACE, MMIP, and WMIP. (1) This section describes the financial eligibility requirements and the rules used to determine a client's participation in the total cost of care for home or community-based long-term care (LTC) services provided under the following programs:

- (a) Community options program entry system (COPES);
- (b) Program of all-inclusive care for the elderly (PACE);
- (c) Medicare/Medicaid integration project (MMIP);
- (d) Washington Medicaid integration partnership (WMIP);
- (e) New Freedom consumer directed services (New Freedom); and
- (f) Hospice services for clients not in a medical institution with gross income at or below the SIL and not eligible for another CN or MN Medicaid program.

(2) To be eligible, a client must:

- (a) Meet the program and age requirements for the specific program, as follows:
 - (i) COPES, per WAC 388-106-0310;
 - (ii) PACE, per WAC 388-106-0705;
 - (iii) MMIP waiver services, per WAC 388-106-0725;
 - (iv) WMIP waiver services, per WAC 388-106-0750;
 - (v) New Freedom, per WAC 388-106-1410; or
 - (vi) Hospice, per chapter 388-551 WAC.
- (b) Meet the aged, blind or disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-475-0050(1);
- (c) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;
- (d) Be residing in a medical facility as defined in WAC 388-500-0005, or likely to be placed in one within the next thirty days in the absence of home or community-based LTC services provided under one of the programs listed in subsection (1) of this section;
- (e) Have attained institutional status as described in WAC 388-513-1320;
- (f) Be determined in need of home or community-based LTC services and be approved for a plan of care as described in subsection (2)(a);
- (g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:
 - (i) Enhanced adult residential care (EARC) facility;
 - (ii) Licensed adult family home (AFH); or
 - (iii) Assisted living (AL) facility.
- (h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and

(i) Meet the resource and income requirements described in subsections (3), (4), and (5) or be an SSI beneficiary not subject to a penalty period as described in subsection (2)(h).

(3) Refer to WAC 388-513-1315 for rules used to determine countable resources, income and eligibility standards.

(4) Excess resources are reduced in an amount equal to medical expenses incurred by the institutional client as described in WAC 388-513-1350 and:

(a) Must result in countable resources being at or below the resource standard in WAC 388-513-1350(1).

(b) If remaining resources are over the standard, the client is ineligible.

(5) Nonexcluded income must be at or below the SIL (300% of the federal benefit rate (FBR)) and is allocated in the following order:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Maintenance and personal needs allowances as described in subsection (7), (8), (9), (10), and (11) of this section;

(c) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(d) Income garnished for child support or withheld according to a child support order in the month of the garnishment (for current and back support):

(i) For the time period covered by the PNA; and

(ii) Is not counted as the child's income when determining the family allocation amount.

(e) Monthly maintenance needs allowance for the community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (6) of this section. This amount:

(i) Is allowed only to the extent that the client's income is made available to the community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for the community spouse's principal residence. These expenses are:

(I) Rent;

(II) Mortgage;

(III) Taxes and insurance;

(IV) Any maintenance care for a condominium or cooperative; and

(V) The food assistance standard utility allowance (for LTC services this is set at the standard utility allowance (SUA) for a four-person household), provided the utilities are not included in the maintenance charges for a condominium or cooperative;

(VI) LESS the standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(VII) Is reduced by the community spouse's gross countable income.

(f) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of

the community or institutionalized spouse based on the living arrangement of the dependent. If the dependent:

(i) Resides with the community spouse, the amount is equal to one-third of the community spouse income allocation as described in WAC 388-513-1380 (5)(b)(i)(A) that exceeds the dependent family member's income;

(ii) Does not reside with the community spouse, the amount is equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members.

(iii) Child support received from a noncustodial parent is the child's income;

(g) Medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.

(6) The amount allocated to the community spouse may be greater than the amount in subsection (5)(e) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(7) A client who receives SSI, and lives at home as defined in WAC 388-106-0010 does not use income to participate in the cost of personal care.

(8) A client who receives SSI and lives in an enhanced adult residential center (EARC), adult family home (AFH) or assisted living (AL) does not use income to participate in the cost of personal care and:

(a) Retains a personal needs allowance (PNA) of sixty dollars and seventy-eight cents; and

(b) Uses income to pay the facility for the cost of room and board.

(c) Room and board is the SSI FBR minus sixty dollars and seventy-eight cents.

(9) A client who is eligible to receive CN-P medicaid described in WAC 388-475-0100 (2)(a) and (b) and lives at home, defined in WAC 388-106-0010, does not use income to participate in the cost of personal care.

(10) A client who is eligible to receive CN-P medicaid described in WAC 388-475-0100 (2)(a) and (b) and lives in an EARC, AFH or AL does not use income to participate in the cost of personal care and:

(a) Retains a personal needs allowance (PNA) of sixty dollars and seventy-eight cents; and

(b) Uses income to pay the facility for the cost of room and board.

(c) Room and board is the SSI FBR minus sixty dollars and seventy-eight cents.

(11) An institutionalized SSI-related client living:

(a) At home, retains a maintenance needs amount equal to the following:

(i) Up to one hundred percent of the one-person FPL, if the client is:

(A) Single; or

(B) Married, and is:

(I) Not living with the community spouse; or

(II) Whose spouse is receiving long-term care (LTC) services outside of the home.

(ii) Up to one hundred percent of the one-person FPL for each client, if both spouses are receiving COPEs, New Freedom, PACE, MMIP, or WMIP services;

(iii) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPEs, New Freedom, PACE, MMIP, or WMIP.

(b) In an EARC, AFH, or AL, retains a maintenance needs amount equal to the SSI FBR and:

(i) Retains a personal needs allowance (PNA) of sixty dollars and seventy-eight cents from the maintenance needs; and

(ii) Pays the remainder of the maintenance needs to the facility for the cost of room and board. (Refer to subsection (14) in this section for allocation of the balance of income remaining over maintenance needs.)

(12) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of personal care. When such a client lives:

(a) At home, the client retains the cash grant amount authorized under the general assistance program;

(b) In an AFH, the client retains a PNA of thirty-eight dollars and eighty-four cents, and pays remaining income and GAX grant to the facility for the cost of board and room; or

(c) In an EARC or AL, the client only receives a PNA of thirty-eight dollars and eighty-four cents and retains it.

(13) The total of the following amounts cannot exceed the SIL:

(a) Maintenance and personal needs allowances as described in subsections (7), (8), (9), (10), (11), and (12).

(b) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (5)(a); and

(c) Guardianship fees and administrative costs in subsection (5)(c).

(14) The client's remaining income after the allocations described in subsections (5) through (12) is the client's responsibility in the cost of care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530, and 2007 c 522, 07-19-127, § 388-515-1505, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-515-1505, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.-530. 06-03-079, § 388-515-1505, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 05-03-077, § 388-515-1505, filed 1/17/05, effective 2/17/05; 02-05-003, § 388-515-1505, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.04.-050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1505, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 74.08.090, 74.04.-050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-515-1505, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

WAC 388-515-1550 Medically needy in-home waiver (MNIW) effective May 1, 2004. This section describes the financial eligibility requirements for waiver services under the medically needy in-home waiver (MNIW) and the rules used to determine a client's responsibility in the total cost of care.

- (1) To be eligible for MNIW, a client must:
- (a) Not meet financial eligibility for Medicaid personal care or the COPEs program;
 - (b) Be eighteen years of age or older;
 - (c) Meet the SSI-related criteria described in WAC 388-475-0050(1);
 - (d) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;
 - (e) In the absence of waiver services described in WAC 388-106-0500, continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;
 - (f) Have attained institutional status as described in WAC 388-513-1320;
 - (g) Have been determined to be in need of waiver services as described in WAC 388-106-0510;
 - (h) Be able to live at home with community support services and choose to remain at home;
 - (i) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and
 - (j) Meet the resource and income requirements described in subsections (2) through (6) of this section.
- (2) The department determines a client's nonexcluded resources under MNIW as described in WAC 388-513-1350.
- (3) Nonexcluded resources, after disregarding excess resources described in subsection (4) of this section, must be at or below the resource standard described in WAC 388-513-1350.
- (4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:
- (a) In an amount equal to incurred medical expenses such as:
 - (i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;
 - (ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; or
 - (iii) Necessary medical care covered under the state's Medicaid plan.
 - (b) As long as the incurred medical expenses:
 - (i) Are not subject to third-party payment or reimbursement;
 - (ii) Are not the result of medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364 and 388-513-1365.
 - (iii) Have not been used to satisfy a previous spenddown liability;
 - (iv) Have not previously been used to reduce excess resources;
 - (v) Have not been used to reduce client responsibility toward cost of care; and
 - (vi) Are amounts for which the client remains liable.
- (5) The department determines a client's countable income under MNIW in the following way:
- (a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);
 - (b) Excludes income described in WAC 388-513-1340;
 - (c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except Medicare premiums, not used to reduce excess resources in subsection (4) of this section;

(e) Allows an income deduction for a nonapplying spouse, equal to the one person medically needy income level (MNIL) less the nonapplying spouse's income, if the nonapplying spouse is living in the same home as the applying person.

(6) A client whose countable income exceeds the MNIL may become eligible for MNIW:

(a) When they have or expect to have medical expenses to offset their income which is over the MNIL; and

(b) Subject to availability in WAC 388-106-0535.

(7) The portion of a client's countable income over the MNIL is called "excess income."

(8) A client who has or will have "excess income" is not eligible for MNIW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(9) The following medical expenses may be used to meet spenddown if not already used in subsection (4) of this section to disregard excess resources or to reduce countable income as described in subsection (5)(d) of this section:

(a) An amount equal to incurred medical expenses such as:

(i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; and

(iii) Necessary medical care covered under the state's Medicaid plan.

(b) The cost of waiver services authorized during the base period.

(c) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Are not the result of medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(iii) Have not been used to satisfy a previous spenddown liability;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(10) Eligibility for MNIW is effective the first full month the client has met spenddown.

(11) In cases where spenddown has been met, medical coverage and MNIW begin the day services are authorized.

(12) A client who meets the requirements for MNIW chooses a three or six month base period. The months must be consecutive calendar months.

(13) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330 (1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) in an amount equal to the one-person Federal Poverty Level (FPL) described in WAC 388-478-0075(4);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources;

(d) Incurred medical expenses described in subsection (4) of this section not used to meet spenddown or reduce excess resources.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.520, 74.09.530 and 2004 c 276 § 206 (6)(b). 07-03-087, § 388-515-1550, filed 1/18/07, effective 2/18/07. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-515-1550, filed 5/17/05, effective 6/17/05. Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-515-1550, filed 7/26/04, effective 8/26/04.]

Chapter 388-517 WAC

MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

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| 388-517-0310 | Eligibility for federal Medicare savings and state-funded Medicare buy-in programs. |
| 388-517-0320 | Medicare savings and state-funded Medicare buy-in programs cover some client costs. |

WAC 388-517-0310 Eligibility for federal Medicare savings and state-funded Medicare buy-in programs. (1) Persons eligible for any Medicare savings programs (MSP) must:

(a) Be entitled to or receiving Medicare Part A. Qualified disabled working individuals (QDWI) clients must be under age sixty-five;

(b) Meet program income standards, see WAC 388-478-0085; and

(c) Have resources at or below twice the resource standards for SSI and SSI related programs, see WAC 388-478-0080(4).

(2) MSP follow categorically needy program rules for SSI related persons in chapter 388-475 WAC.

(3) MSP clients are entitled to a fair hearing when the department takes an adverse action such as denying or terminating MSP benefits.

(4) The department subtracts the allocations and deductions described under WAC 388-513-1380 from a long-term care client's countable income and resources when determining MSP eligibility:

(a) Allocations to a spouse and/or dependent family member; and

(b) Client participation in cost of care.

(5) Medicaid eligibility may affect MSP eligibility, as follows:

(a) Qualified Medicare beneficiaries (QMB) and specified low income beneficiaries (SLMB) clients can receive Medicaid and still be eligible to receive QMB or SLMB benefits.

(b) Qualified individuals (QI-1) and qualified disabled working individuals (QDWI) clients who begin to receive Medicaid are no longer eligible for QI-1 or QDWI benefits.

(6) Every year, when the federal poverty level changes:

(a) The department adjusts income standards for MSP and state funded Medicare buy-in programs, see WAC 388-478-0085.

(b) The department begins to count the annual Social Security cost-of-living (COLA) increase on April 1st each year when determining eligibility for MSP and state funded Medicaid buy-in programs.

(7) There is no income limit for the state-funded Medicare buy-in program. The state-funded Medicare buy-in program is for clients who receive Medicaid but do not qualify for the federal MSP.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 U.S.C. Section 1396a. 07-15-032, § 388-517-0310, filed 7/12/07, effective 8/12/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0310, filed 7/1/05, effective 8/1/05.]

WAC 388-517-0320 Medicare savings and state-funded Medicare buy-in programs cover some client costs.

(1) For qualified Medicare beneficiary (QMB) clients, the department pays:

(a) Medicare Part A premiums (if any);

(b) Medicare Part B premiums;

(c) Coinsurance, deductibles, and copayments for Medicare Part A, Part B, and Medicare advantage Part C with the following conditions:

(i) Only the Part A and Part B deductible, coinsurance, and copayments up to the Medicare or Medicaid allowed amount, whichever is less (WAC 388-502-0110), if the service is covered by Medicare and Medicaid.

(ii) Only the deductible, coinsurance, and copayments up to the Medicare allowed amount if the service is covered only by Medicare.

(d) Copayments for QMB-eligible clients enrolled in Medicare advantage Part C up to the Medicare or Medicaid allowed amount whichever is less (WAC 388-502-0110).

(e) QMB Part A and/or Part B premiums the first of the month following the month the QMB eligibility is determined.

(2) For specified low-income Medicare beneficiary (SLMB) clients, the department pays Medicare Part B premiums effective up to three months prior to the certification period if eligible for those months. No other payments are made for SLMBs.

(3) For qualified individual (QI-1) clients, the department pays Medicare Part B premiums effective up to three months prior to the certification period if eligible for those months unless:

(a) The client receives Medicaid categorically needy (CN) or medically needy (MN) benefits; and/or

(b) The department's annual federal funding allotment is spent. The department resumes QI-1 benefit payments the beginning of the next calendar year.

(4) For qualified disabled working individual (QDWI) clients, the department pays Medicare Part A premiums effective up to three months prior to the certification period if eligible for those months. The department stops paying Medicare Part A premiums if the client begins to receive CN or MN Medicaid.

(5) For state-funded Medicare buy-in program clients, the department pays:

(a) Medicare Part B premiums; and

(b) Only the Part A and B co-insurance, deductibles, and co-payments up to the Medicare or Medicaid allowed

amount, whichever is less (WAC 388-502-0110), if the service is covered by Medicare and Medicaid.

(6) For the dual-eligible client, (a client receiving both Medicare and CN or MN medical coverage) the department pays as follows:

(a) If the service is covered by Medicare and Medicaid, Medicaid pays only the deductible, and coinsurance up to the Medicare or Medicaid allowed amount, whichever is less (WAC 388-502-0110); and

(b) Copayments for Medicare advantage Part C up to the Medicare or Medicaid allowed copayment amount, whichever is less (WAC 388-502-0110);

(c) If no Medicaid rate exists, the department will deny payment unless the client is also QMB then refer to section (1) above.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 U.S.C. Section 1396a. 07-15-032, § 388-517-0320, filed 7/12/07, effective 8/12/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0320, filed 7/1/05, effective 8/1/05.]

Chapter 388-530 WAC

PRESCRIPTION DRUGS (OUTPATIENT)

WAC

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| 388-530-1000 | Outpatient drug program—General. |
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| 388-530-2000 | Covered—Outpatient drugs, devices, and drug-related supplies. |
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| 388-530-7900 | Drugs purchased under the Public Health Service (PHS) Act. |
| 388-530-8000 | Reimbursement method—Estimated acquisition cost (EAC). |
| 388-530-8050 | Reimbursement—Federal upper limit (FUL). |
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| 388-530-8150 | Reimbursement—Automated maximum allowable cost (AMAC). |

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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| 388-530-1100 | Covered drugs, devices, and pharmaceutical supplies. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1100, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1100, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1100, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
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| 388-530-1125 | Drug rebate program. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1125, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1125, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-029, § 388-530-1125, filed 12/7/00, effective 1/7/01.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1150 | Noncovered drugs and pharmaceutical supplies and reimbursement limitations. [Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-530-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1150, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1150, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1150, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1150, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1200 | Prior authorization program. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1200, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1200, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1200, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1200, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1250 | Prior authorization process. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1250, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1250, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1250, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1250, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1260 | Therapeutic consultation service. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1260, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.08.090, 74.04.050, 01-24-066, § 388-530-1260, filed 11/30/01, effective 1/2/02.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1270 | Mail-order services. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1270, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.08.090, 74.09.510, and 2002 c 371 (2001-03 Revised Omnibus Operating Budget - 2002 Supp.). 03-05-043, § 388-530-1270, filed 2/13/03, effective 3/16/03.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. |
| 388-530-1280 | Preferred drug list(s). [Statutory Authority: RCW 69.41.190, 70.14.050, and 74.08.090. 05-11-078, § 388-530-1280, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, |

- 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1280, filed 12/30/04, effective 1/30/05.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1290 Therapeutic interchange program (TIP). [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1290, filed 12/30/04, effective 1/30/05.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1300 General reimbursement methodology. [Statutory Authority: RCW 74.08.090 and 74.09.520. 04-01-089, § 388-530-1300, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1300, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1300, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1300, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1350 Estimated acquisition cost (EAC) methodology. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1350, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1350, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1350, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1360 Certified average wholesale price (CAWP). [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1360, filed 8/9/02, effective 9/9/02.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1400 Maximum allowable cost (MAC) methodology. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1400, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1400, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1400, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1400, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1405 Automated maximum allowable cost (AMAC). [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1405, filed 8/9/02, effective 9/9/02.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1410 Federal upper limit (FUL) methodology. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1410, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1410, filed 12/7/00, effective 1/7/01.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1425 Payment methodology for drugs purchased under the Public Health Service (PHS) Act. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1425, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1425, filed 12/7/00, effective 1/7/01.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1450 Dispensing fee determination. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1450, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1450, filed 12/7/00, effective 1/7/01.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1500 Reimbursement for compounded prescriptions. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1500, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1500, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1500, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1550 Unit dose drug delivery systems. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1550, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1550, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1550, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1600 Unit dose pharmacy billing requirements. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1600, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1600, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.04.050, 74.08.090, 42 CFR 447.333 and Attachment 4.19-B, Page 2-b of the State Plan under Title XIX of the Social Security Act. 98-14-005, § 388-530-1600, filed 6/18/98, effective 7/19/98. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1600, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1625 Compliance packaging services. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1625, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1625, filed 12/7/00, effective 1/7/01.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1650 Reimbursement for pharmaceutical supplies. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1650, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1650, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1650, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1700 Drugs and drug-related supplies from nonpharmacy providers. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1700, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1700, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1700, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1750 Drugs and pharmaceutical supplies for clients with any third-party coverage. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1750, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.09.035. 00-14-071, § 388-530-1750, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1750, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.

- 388-530-1800 Requirements for pharmacy claim payment. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-1800, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-1800, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1850 Drug use review (DUR) board. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 2003 1st sp.s. c 29 § 10, 42 C.F.R. 456.716, RCW 41.05.160. 04-11-009, § 388-530-1850, filed 5/5/04, effective 6/5/04. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-1850, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1850, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1850, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1900 Drug use and claims review. [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1900, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-1900, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1900, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1900, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-1950 Point-of-sale (POS) system/prospective drug use review (Pro-DUR). [Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1950, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-1950, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1950, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-08-018 (Order 3960), § 388-530-1950, filed 3/26/96, effective 4/26/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.
- 388-530-2050 Reimbursement for out-of-state prescriptions. [Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-2050, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-2050, filed 12/7/00, effective 1/7/01; 00-01-088, § 388-530-2050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.] Repealed by 07-20-049, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.

WAC 388-530-1000 Outpatient drug program—

General. (1) The purpose of the outpatient drug program is to pay providers for outpatient drugs, devices, and drug-related supplies according to department rules and subject to the limitations and requirements in this chapter.

(2) The department reimburses for outpatient drugs, devices, and pharmaceutical supplies that are:

(a) Covered. Refer to WAC 388-530-2000 for covered drugs, devices, and drug-related supplies and to WAC 388-530-2100 for noncovered drugs and drug-related supplies;

(b) Prescribed by a provider with prescribing authority (see exceptions for family planning and emergency contra-

ception for woman [women] eighteen years of age and older in WAC 388-530-2000 (1)(b);

(c) Within the scope of an eligible client's medical assistance program;

(d) Medically necessary as defined in WAC 388-500-0005 and determined according to the process found in WAC 388-501-0165; and

(e) Authorized, as required within this chapter;

(f) Billed according to WAC 388-502-0150 and 388-502-0160; and

(g) Billed according to the requirements of this chapter.

(3) The department may not pay for prescriptions written by healthcare practitioners whose application for a core provider agreement (CPA) has been denied, or whose CPA has been terminated.

(4) The department may not pay for prescriptions written by non-CPA healthcare practitioners who do not have a current core provider agreement with the department when the department determines there is a potential danger to the client's health and/or safety.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09-700. 07-20-049, § 388-530-1000, filed 9/26/07, effective 11/1/07; 06-24-036, § 388-530-1000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102.02-17-023, § 388-530-1000, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1000, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1000, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1050 Definitions. In addition to the definitions and abbreviations found in WAC 388-500-0005, Medical definitions, the following definitions apply to this chapter.

"Active ingredient" - The chemical component of a drug responsible for a drug's prescribed/intended therapeutic effect. The department limits coverage of active ingredients to those with an eleven-digit national drug code (NDC) and those specifically authorized by the department.

"Actual acquisition cost (AAC)" - The net cost a provider paid for a drug, device, or drug-related supply marketed in the package size purchased. The ACC includes discounts, rebates, charge backs and other adjustments to the price of the drug, device or drug-related supply, but excludes dispensing fees.

"Administer" - Includes the direct application of a prescription drug or device by injection, insertion, inhalation, ingestion, or any other means, to the body of a patient by a practitioner, or at the direction of the practitioner.

"Appointing authority" - For the evidence-based prescription drug program of the participating agencies in the state-operated health care programs, the following persons acting jointly: The administrator of the health care authority (HCA), the secretary of the department of social and health services (DSHS), and the director of the department of labor and industries (L&I).

"Automated authorization" - Adjudication of claims using submitted NCPDP data elements or claims history to verify that the department's authorization requirements have been satisfied without the need for the department to request additional clinical information.

"Automated maximum allowable cost (AMAC)" - The rate established by the department for a multiple-source

drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products at least one of which must be under a federal drug rebate contract.

"Average manufacturer price (AMP)" - The average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies.

"Average sales price (ASP)" - The weighted average of all nonfederal sales to wholesalers net of charge backs, discounts, rebates, and other benefits tied to the purchase of the drug product, whether it is paid to the wholesaler or the retailer.

"Average wholesale price (AWP)" - The average price of a drug product that is calculated from wholesale list prices nationwide at a point in time and reported to the department by the department's drug file contractor.

"Combination drug" - A commercially available drug including two or more active ingredients.

"Compendia of drug information" includes the following:

(1) The American Hospital Formulary Service Drug Information;

(2) The United States Pharmacopeia Drug Information; and

(3) DRUGDEX Information System.

"Compounding" - The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

"Deliver or delivery" - The transfer of a drug or device from one person to another.

"Dispense as written (DAW)" - An instruction to the pharmacist forbidding substitution of a generic drug or a therapeutically equivalent product for the specific drug product prescribed.

"Dispensing fee" - The fee the department sets to pay pharmacy providers for dispensing department-covered prescriptions. The fee is the department's maximum reimbursement for expenses involved in the practice of pharmacy and is in addition to the department's reimbursement for the costs of covered ingredients.

"Drug evaluation matrix" - The criteria-based scoring sheet used to objectively and consistently evaluate the food and drug administration (FDA) approved drugs to determine drug coverage status.

"Drug file" - A list of drug products, pricing and other information provided to the department and maintained by a drug file contractor.

"Drug file contractor" - An entity which has been contracted to provide regularly updated information on drugs, devices, and drug-related supplies at specified intervals, for the purpose of pharmaceutical claim adjudication. Information is provided specific to individual national drug codes, including product pricing.

"Drug rebates" - Reimbursements provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services (DHHS).

"Drug-related supplies" - Nondrug items necessary for the administration, delivery, or monitoring of a drug or drug regimen.

"Drug use review (DUR)" - A review of covered outpatient drug use that assures prescriptions are appropriate, med-

ically necessary, and not likely to result in adverse medical outcomes.

"Effectiveness" - The extent to which a given intervention is likely to produce beneficial results for which it is intended in ordinary circumstances.

"Efficacy" - The extent to which a given intervention is likely to produce beneficial effects in the context of the research study.

"Emergency kit" - A set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

"Endorsing practitioner" - A practitioner who has reviewed the Washington preferred drug list (PDL) and has enrolled with the health care authority (HCA), agreeing to allow therapeutic interchange (substitution) of a preferred drug for any nonpreferred drug in a given therapeutic class on the Washington PDL.

"Estimated acquisition cost (EAC)" - The department's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.

"Evidence-based" and **"evidenced-based medicine (EBM)"** - The application of a set of principles and a method for the review of well-designed studies and objective clinical data to determine the level of evidence that proves to the greatest extent possible, that a healthcare service is safe, effective and beneficial when making population-based coverage policies or individual medical necessity decisions.

"Evidence-based practice center" - A research organization that has been designated by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. government to conduct systematic reviews of all the evidence to produce evidence tables and technology assessments to guide health care decisions.

"Federal upper limit (FUL)" - The maximum allowable reimbursement set by the Centers for Medicare and Medicaid Services (CMS) for a multiple-source drug.

"Four brand name prescriptions per calendar month limit" - The maximum number of paid prescription claims for brand name drugs that the department allows for each client in a calendar month without a complete review of the client's drug profile.

"Generic drug" - A nonproprietary drug that is required to meet the same bioequivalency tests as the original brand name drug.

"Inactive ingredient" - A drug component that remains chemically unchanged during compounding but serves as the:

(1) Necessary vehicle for the delivery of the therapeutic effect; or

(2) Agent for the intended method or rate of absorption for the drug's active therapeutic agent.

"Ingredient cost" - The portion of a prescription's cost attributable to the covered drug ingredients or chemical components.

"Innovator multiple source drug" - As set forth in Section 1927 (k)(7)(A)(ii) of the Social Security Act, includes all covered outpatient drugs approved under a new drug application (NDA), product license approval (PLA),

establishment license approval (ELA), or antibiotic drug approval (ADA). A covered outpatient drug marketed by a cross-licensed producer or distributor under the approved new drug application will be included as an innovator multiple source drug when the drug product meets this definition.

"Less than effective drug" or **"DESI"** - A drug for which:

(1) Effective approval of the drug application has been withdrawn by the Food and Drug Administration (FDA) for safety or efficacy reasons as a result of the drug efficacy study implementation (DESI) review; or

(2) The secretary of the Department of Health and Human Services (DHHS) has issued a notice of an opportunity for a hearing under section 505(e) of the federal Food, Drug, and Cosmetic Act on a proposed order of the secretary to withdraw approval of an application for such drug under such section because the secretary has determined the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling.

"Long-term therapy" - A drug regimen a client receives or will receive continuously through and beyond ninety days.

"Maximum allowable cost (MAC)" - The maximum amount that the department reimburses for a drug, device, or drug-related supply.

"Medically accepted indication" - Any use for a covered outpatient drug:

(1) Which is approved under the federal Food, Drug, and Cosmetic Act; or

(2) The use of which is supported by one or more citations included or approved for inclusion in any of the compendia of drug information, as defined in this chapter.

"Modified unit dose delivery system" (also known as blister packs or "bingo/punch cards") - A method in which each patient's medication is delivered to a nursing facility:

(1) In individually sealed, single dose packages or "blisters"; and

(2) In quantities for one month's supply, unless the prescriber specifies a shorter period of therapy.

"Multiple-source drug" - A drug marketed or sold by:

(1) Two or more manufacturers or labelers; or

(2) The same manufacturer or labeler:

(a) Under two or more different proprietary names; or

(b) Under a proprietary name and a generic name.

"National drug code (NDC)" - The eleven-digit number the FDA and manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The NDC is composed of digits in 5-4-2 groupings. The first five digits comprise the labeler code assigned to the manufacturer by the Food and Drug Administration (FDA). The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"Noncontract drugs" - Are drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services.

"Nonpreferred drug" - A drug that has not been selected as a preferred drug within the therapeutic class(es) of drugs on the preferred drug list.

"Obsolete NDC" - A national drug code replaced or discontinued by the manufacturer or labeler.

"Over-the-counter (OTC) drugs" - Drugs that do not require a prescription before they can be sold or dispensed.

"Peer reviewed medical literature" - A research study, report, or findings regarding the specific use of a drug that has been submitted to one or more professional journals, reviewed by experts with appropriate credentials, and subsequently published by a reputable professional journal. A clinical drug study used as the basis for the publication must be a double blind, randomized, placebo or active control study.

"Pharmacist" - A person licensed in the practice of pharmacy by the state in which the prescription is filled.

"Pharmacy" - Every location licensed by the state board of pharmacy in the state where the practice of pharmacy is conducted.

"Pharmacy and therapeutic (P&T) committee" - The independent Washington state committee created by RCW 41.05.021 (1)(a)(iii) and 70.14.050. At the election of the department, the committee may serve as the drug use review board provided for in WAC 388-530-4000.

"Point-of-sale (POS)" - A pharmacy claims processing system capable of receiving and adjudicating claims on-line.

"Practice of pharmacy" - The practice of and responsibility for:

(1) Accurately interpreting prescription orders;

(2) Compounding drugs;

(3) Dispensing, labeling, administering, and distributing of drugs and devices;

(4) Providing drug information to the client that includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices;

(5) Monitoring of drug therapy and use;

(6) Proper and safe storage of drugs and devices;

(7) Documenting and maintaining records;

(8) Initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs; and

(9) Participating in drug use reviews and drug product selection.

"Practitioner" - An individual who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner.

"Preferred drug" - Drug(s) of choice within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

"Preferred drug list (PDL)" - The department's list of drugs of choice within selected therapeutic drug classes.

"Prescriber" - A physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. See WAC 246-863-100 for pharmacists' prescriptive authority.

"Prescription" - An order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices, in the course of the practitioner's professional practice, for a legitimate medical purpose.

"Prescription drugs" - Drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

"Prospective drug use review (Pro-DUR)" - A process in which a request for a drug product for a particular client is screened, before the product is dispensed, for potential drug therapy problems.

"Reconstitution" - The process of returning a single active ingredient, previously altered for preservation and storage, to its approximate original state. Reconstitution is not compounding.

"Retrospective drug use review (Retro-DUR)" - The process in which drug utilization is reviewed on an ongoing periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or not medically necessary care.

"Risk/benefit ratio" - The result of assessing the side effects of a drug or drug regimen compared to the positive therapeutic outcome of therapy.

"Single source drug" - A drug produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA).

"Substitute" - To replace a prescribed drug, with the prescriber's authorization, with:

- (1) An equivalent generic drug product of the identical base or salt as the specific drug product prescribed; or
- (2) A therapeutically equivalent drug other than the identical base or salt.

"Systematic review" - A specific and reproducible method to identify, select, and appraise all the studies that meet minimum quality standards and are relevant to a particular question. The results of the studies are then analyzed and summarized into evidence tables to be used to guide evidence-based decisions.

"Terminated NDC" - [a] An eleven-digit national drug code (NDC) that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life.

"Therapeutic alternative" - A drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile when administered to patients in a therapeutically equivalent dosage.

"Therapeutic class" - A group of drugs used for the treatment, remediation, or cure of a specific disorder or disease.

"Therapeutic interchange" - To dispense a therapeutic alternative to the prescribed drug when an endorsing practitioner who has indicated that substitution is permitted, prescribes the drug. See therapeutic interchange program (TIP).

"Therapeutic interchange program (TIP)" - The process developed by participating state agencies under RCW 69.41.190 and 70.14.050, to allow prescribers to endorse a Washington preferred drug list, and in most cases, requires pharmacists to automatically substitute a preferred, equivalent drug from the list.

"Therapeutically equivalent" - Drug products that contain different chemical structures but have the same effi-

cacy and safety when administered to an individual, as determined by:

- (1) Information from the Food and Drug Administration (FDA);
- (2) Published and peer-reviewed scientific data;
- (3) Randomized controlled clinical trials; or
- (4) Other scientific evidence.

"Tiered dispensing fee system" - A system of paying pharmacies different dispensing fee rates, based on the individual pharmacy's total annual prescription volume and/or the drug delivery system used.

"True unit dose delivery" - A method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage.

"Unit dose drug delivery" - True unit dose or modified unit dose delivery systems.

"Usual and customary charge" - The fee that the provider typically charges the general public for the product or service.

"Washington preferred drug list (Washington PDL)" - The list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for purchase of drugs in state-operated health care programs.

"Wholesale acquisition cost" - The price paid by a wholesaler for drugs purchased from a manufacturer.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-1050, filed 9/26/07, effective 11/1/07. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1050, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1050, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-24-066, § 388-530-1050, filed 11/30/01, effective 1/2/02; 01-01-028, § 388-530-1050, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.-090. 96-21-031, § 388-530-1050, filed 10/9/96, effective 11/9/96.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-530-2000 Covered—Outpatient drugs, devices, and drug-related supplies. (1) The department covers:

(a) Outpatient drugs, including over-the-counter drugs, as defined in WAC 388-530-1050, subject to the limitations and requirements in this chapter, when:

(i) The drug is approved by the Food and Drug Administration (FDA);

(ii) The drug is for a medically accepted indication as defined in WAC 388-530-1050;

(iii) The drug is not excluded from coverage under WAC 388-530-2100; and

(iv) The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 388-530-7500 which describes the drug rebate program.

(b) Family planning drugs, devices, and drug-related supplies per chapter 388-532 WAC and as follows:

(i) Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies without a prescription when the department determines it necessary for client access and safety.

(ii) Family planning drugs that do not meet the federal drug rebate requirement in WAC 388-530-7500 on a case-by-case basis; and

(iii) Contraceptive patches, contraceptive rings, and oral contraceptives, only when dispensed in at least a three-month supply, unless otherwise directed by the prescriber. There is no required minimum for how many cycles of emergency contraception may be dispensed.

(c) Prescription vitamins and mineral products, only as follows:

(i) When prescribed for clinically documented deficiencies;

(ii) Prenatal vitamins, when prescribed and dispensed to pregnant women; or

(iii) Fluoride varnish for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

(d) Drug-related devices and drug-related supplies as an outpatient pharmacy benefit when:

(i) Prescribed by a provider with prescribing authority;

(ii) Essential for the administration of a covered drug;

(iii) Not excluded from coverage under WAC 388-530-2100; and

(iv) Determined by the department, that a product covered under chapter 388-543 WAC Durable medical equipment and supplies should be available at retail pharmacies.

(e) Preservatives, flavoring and/or coloring agents, only when used as a suspending agent in a compound.

(2) Coverage determinations for the department are decided by:

(a) The department in consultation with federal guidelines; or

(b) The drug use review (DUR) board; and

(c) The department's medical consultants and the department's pharmacist(s).

(3) The department does not reimburse for any drug, device, or drug-related supply not meeting the coverage requirements under this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-2000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-2100 Noncovered—Outpatient drugs and pharmaceutical supplies. (1) The department does not cover:

(a) A drug that is:

(i) Not approved by the Food and Drug Administration (FDA); or

(ii) Prescribed for nonmedically accepted indication, including diagnosis, dose, or dosage schedule that is not evidenced-based.

(b) A drug prescribed:

(i) For weight loss or gain;

(ii) For infertility, frigidity, impotency;

(iii) For sexual or erectile dysfunction;

(iv) For cosmetic purposes or hair growth; or

(v) To promote tobacco cessation, except as described in WAC 388-533-0400(20) tobacco cessation for pregnant women.

(c) Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927 (d)(2)(K) of the Social Security Act, unless such drugs are used to treat a condition other than

sexual or erectile dysfunction, and these uses have been approved by the Food and Drug Administration.

(d) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(e) Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(f) A product:

(i) With an obsolete national drug code (NDC) for more than two years;

(ii) With a terminated NDC;

(iii) Whose shelf life has expired; or

(iv) Which does not have an eleven-digit NDC.

(g) Any drug regularly supplied by other public agencies as an integral part of program activity (e.g., immunization vaccines for children).

(h) Free pharmaceutical samples.

(2) A client can request an exception to rule (ETR) as described in WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-2100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-3000 When the department requires authorization. Pharmacies must obtain authorization for covered drugs, devices, or drug-related supplies in order to receive reimbursement as described in this section.

(1) The department's pharmacists and medical consultants:

(a) Have determined that authorization for the drug, device, or drug-related supply is required, as described in WAC 388-530-3100; or

(b) Have not yet reviewed the manufacturer's dossier of drug information submitted in the Academy of Managed Care Pharmacy (AMCP) format.

(2) The drug, device, or drug-related supply is in the therapeutic drug class on the Washington preferred drug list and the product is one of the following:

(a) Nonpreferred as described in WAC 388-530-4100; and

(i) The prescriber is a nonendorsing practitioner; or

(ii) The drug is designated as exempt from the therapeutic interchange program per WAC 388-530-4100(6) or 388-530-4150 (2)(c);

(b) Preferred for a special population or specific indication and has been prescribed by a nonendorsing practitioner under conditions for which the drug, device, or drug-related supply is not preferred; or

(c) Determined to require authorization for safety.

(3) For the purpose of promoting safety, efficacy, and effectiveness of drug therapy, the department identifies clients or groups of clients who would benefit from further clinical review.

(4) The department designates the prescriber(s) as requiring authorization because the prescriber(s) is under department review or is sanctioned for substandard quality of care.

(5) Utilization data indicate there are health and safety concerns or the potential for misuse and abuse. Examples of utilization concerns include:

- (a) Multiple prescriptions filled of the same drug in the same calendar month;
 - (b) Prescriptions filled earlier than necessary for optimal therapeutic response;
 - (c) Therapeutic duplication;
 - (d) Therapeutic contraindication;
 - (e) Excessive dosing, excessive duration of therapy, or subtherapeutic dosing as determined by FDA labeling or the compendia of drug information;
 - (f) Number of brand prescriptions filled per calendar month; and
 - (g) Number of prescriptions filled per month in total or by therapeutic drug class.
- (6) The pharmacy requests reimbursement in excess of the maximum allowable cost and the drug has been prescribed with instructions to dispense as written.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-3000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-3100 How the department determines when a drug requires authorization. (1) The department's pharmacists and medical consultants evaluate new covered drugs, new covered indications, or new dosages approved by the Food and Drug Administration (FDA) to determine the drug authorization requirement.

(a) The clinical team uses a drug evaluation matrix to evaluate and score the benefit/risk assessment and cost comparisons of drugs to similar existing drugs based on quality evidence contained in compendia of drug information and peer-reviewed medical literature.

(b) In performing this evaluation the clinical team may consult with other department clinical staff, financial experts, and program managers. The department may also consult with an evidence-based practice center, the drug use review (DUR) board, and/or medical experts in this evaluation.

(c) Information reviewed in the drug evaluation matrix includes, but is not limited to, the following:

- (i) The drug, device, or drug-related supply's benefit/risk ratio;
 - (ii) Potential for clinical misuse;
 - (iii) Potential for client misuse/abuse;
 - (iv) Narrow therapeutic indication;
 - (v) Safety concerns;
 - (vi) Availability of less costly therapeutic alternatives;
- and
- (vii) Product cost and outcome data demonstrating the drug, device, or drug-related supply's cost effectiveness.

(d) Based on the clinical team's evaluation and the drug evaluation matrix score, the department may determine that the drug, device, or drug-related supply:

- (i) Requires authorization;
- (ii) Requires authorization to exceed department established limitations; or
- (iii) Does not require authorization.

(2) Drugs in therapeutic classes on the Washington preferred drug list are not subject to determination of authorization requirements through the drug evaluation matrix. Authorization requirements are determined by their preferred status according to WAC 388-530-4100.

(3) The department periodically reviews existing drugs, devices, or drug-related supplies and reassigns authorization

requirements as necessary according to the same provisions as outlined above for new drugs, devices, or pharmaceutical supplies.

(4) For any drug, device, or drug-related supply with limitations or requiring authorization, the department may elect to apply automated authorization criteria according to WAC 388-530-3200.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-3100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-3200 The department's authorization process. (1) The department may establish automated ways for pharmacies to meet authorization requirements for specified drugs, devices, and drug-related supplies, or circumstances as listed in WAC 388-530-3000(4) including, but are not limited to:

(a) Use of expedited authorization codes as published in the department's prescription drug program billing instructions and numbered memoranda;

(b) Use of specified values in national council of prescription drug programs (NCPDP) claim fields;

(c) Use of diagnosis codes; and

(d) Evidence of previous therapy within the department's claim history.

(2) When the automated requirements in subsection (1) of this section do not apply or cannot be satisfied, the pharmacy provider must request authorization from the department before dispensing. The pharmacy provider must:

(a) Ensure the request states the medical diagnosis and includes medical justification for the drug, device, drug-related supply, or circumstance as listed in WAC 388-530-3000(4); and

(b) Keep documentation on file of the prescriber's medical justification that is communicated to the pharmacy by the prescriber at the time the prescription is filled. The records must be retained for the period specified in WAC 388-502-0020 (1)(c).

(3) When the department receives the request for authorization:

(a) The department acknowledges receipt:

(i) Within twenty-four hours if the request is received during normal state business hours; or

(ii) Within twenty-four hours of opening for business on the next business day if received outside of normal state business hours.

(b) The department reviews all evidence submitted and takes one of the following actions within fifteen business days:

(i) Approves the request;

(ii) Denies the request if the requested service is not medically necessary; or

(iii) Requests the prescriber submit additional justifying information.

(A) The prescriber must submit the additional information within ten days of the department's request.

(B) The department approves or denies the request within five business days of the receipt of the additional information.

(C) If the prescriber fails to provide the additional information within ten days, the department will deny the

requested service. The department sends a copy of the request to the client at the time of denial.

(4) The department's authorization may be based on, but not limited to:

(a) Requirements under this chapter and WAC 388-501-0165;

(b) Client safety;

(c) Appropriateness of drug therapy;

(d) Quantity and duration of therapy;

(e) Client age, gender, pregnancy status, or other demographics; and

(f) The least costly alternative between two or more products of equal effectiveness.

(5) The department evaluates request for authorization of covered drugs, devices, and drug-related supplies that exceed limitations in this chapter on a case-by-case basis in conjunction with subsection (4) of this section and WAC 388-501-0169.

(6) If a provider needs authorization to dispense a covered drug outside of normal state business hours, the provider may dispense the drug without authorization only in an emergency. The department must receive justification from the provider within seventy-two hours of the fill date, excluding weekends and Washington state holidays, to be paid for the emergency fill.

(7) The department may remove authorization requirements under WAC 388-530-3000 for, but not limited to, the following:

(a) Prescriptions written by specific practitioners based on consistent high quality of care; or

(b) Prescriptions filled at specific pharmacies and billed to the department at the pharmacies' lower acquisition cost.

(8) Authorization requirements in WAC 388-530-3000 are not a denial of service.

(9) Rejection of a claim due to the authorization requirements listed in WAC 388-530-3000 is not a denial of service.

(10) When a claim requires authorization, the pharmacy provider must request authorization from the department. If the pharmacist fails to request authorization as required, the department does not consider this a denial of service.

(11) Denials that result as part of the authorization process will be issued by the department in writing.

(12) The department's authorization:

(a) Is a decision of medical appropriateness; and

(b) Does not guarantee payment.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09-700.07-20-049, § 388-530-3200, filed 9/26/07, effective 11/1/07.]

WAC 388-530-4000 Drug use review (DUR) board.

In accordance with 42 CFR 456.716, the department establishes a drug use review (DUR) board.

(1) The DUR board:

(a) Includes health professionals who are actively practicing and licensed in the state of Washington and who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of outpatient drugs;

(ii) The clinically appropriate dispensing and monitoring of outpatient drugs;

(iii) Drug use review, evaluation, and intervention; and

(iv) Medical quality assurance.

(b) Is made up of at least one-third but not more than fifty-one percent physicians, and at least one-third pharmacists.

(2) The department may appoint members of the pharmacy and therapeutics committee established by the health care authority (HCA) under chapter 182-50 WAC or other qualified individuals to serve as members of the DUR board.

(3) The DUR board meets periodically to:

(a) Advise the department on drug use review activities;

(b) Review provider and patient profiles;

(c) Review scientific literature to establish evidence-based guidelines for the appropriate use of drugs, including the appropriate indications and dosing;

(d) Recommend adoption of standards and treatment guidelines for drug therapy;

(e) Recommend interventions targeted toward correcting drug therapy problems; and

(f) Produce an annual report.

(4) The department has the authority to accept or reject the recommendations of the DUR board in accordance with 42 CFR 456.716(c).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09-700.07-20-049, § 388-530-4000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-4050 Drug use and claims review. (1)

The department's drug use review (DUR) consists of:

(a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:

(i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;

(ii) Screen for potential drug therapy problems; and

(iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations.

(b) A retrospective drug use review (Retro-DUR), in which the department provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

(2) The department reviews a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, the department may implement corrective action that includes, but is not limited to:

(a) Educating the provider regarding the problem practice(s);

(b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;

(c) Recouping the payment for the drug(s); and/or

(d) Terminating the provider's core provider agreement (CPA).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09-700.07-20-049, § 388-530-4050, filed 9/26/07, effective 11/1/07.]

WAC 388-530-4100 Washington preferred drug list (PDL). Under RCW 69.41.190 and 70.14.050, the department, and other state agencies cooperate in developing and maintaining the Washington preferred drug list.

(1) Washington state contracts with evidence-based practice center(s) for systematic reviews of drug(s).

(2) The pharmacy and therapeutics (P&T) committee reviews and evaluates the safety, efficacy, and outcomes of prescribed drugs, using evidence-based information provided by the evidence-based practice center(s).

(3) The P&T committee makes recommendations to state agencies as to which drug(s) to include on the Washington PDL, under chapter 182-50 WAC.

(4) The appointing authority makes the final selection of drugs included on the Washington PDL.

(5) Drugs in a drug class on the Washington PDL, that have been studied by the evidence-based practice center(s) and reviewed by the P&T committee, and which have not been selected as preferred are considered nonpreferred drugs and are subject to the therapeutic interchange program (TIP) and dispense as Written (DAW) rules under WAC 388-530-4150.

(6) Drugs in a drug class on the Washington PDL that have not been studied by the evidence-based practice center(s) and have not been reviewed by the P&T committee will be treated as nonpreferred drugs not subject to the dispense as written (DAW) or the therapeutic interchange program (TIP).

(7) A nonpreferred drug, which the department determines as covered, is considered for authorization after the client has:

(a) Tried and failed or is intolerant to at least one preferred drug; and

(b) Met department established criteria for the nonpreferred drug.

(8) Drugs in a drug class on the Washington PDL may be designated as preferred drugs for special populations or specific indications.

(9) Drugs in a drug class on the Washington PDL may require authorization for safety.

(10) Combination drugs are not on the Washington PDL and are considered for authorization according to WAC 388-530-3100.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-4100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-4150 Therapeutic interchange program (TIP). This section contains the department's rules for the endorsing practitioner therapeutic interchange program (TIP). TIP is established under RCW 69.41.190 and 70.14.050. The statutes require state-operated prescription drug programs to allow physicians and other prescribers to endorse a Washington preferred drug list (PDL) and, in most cases, requires pharmacists to automatically substitute a preferred, equivalent drug from the list.

(1) The therapeutic interchange program (TIP) applies only to drugs:

- (a) Within therapeutic classes on the Washington PDL;
- (b) Studied by the evidence-based practice center(s);
- (c) Reviewed by the P&T committee; and
- (d) Prescribed by an endorsing practitioner.

(2) TIP does not apply:

- (a) To drugs that require authorization;
- (b) To drugs with specific limitations;

(c) When the pharmacy and therapeutics (P&T) committee determines that TIP does not apply to the therapeutic class on the PDL; or

(d) To a drug prescribed by a nonendorsing practitioner.

(3) A practitioner who wishes to become an endorsing practitioner must specifically enroll with the health care authority (HCA) as an endorsing practitioner, under the provisions of chapter 182-50 WAC.

(4) When an endorsing practitioner writes a prescription for a client for a nonpreferred drug, or for a preferred drug for a special population or indication other than the client's population or indication, and indicates that substitution is permitted, the pharmacist must:

(a) Dispense a preferred drug in that therapeutic class in place of the nonpreferred drug; and

(b) Notify the endorsing practitioner of the specific drug and dose dispensed.

(5) When an endorsing practitioner determines that a nonpreferred drug is medically necessary, all of the following apply:

(a) The practitioner must indicate that the prescription is to be dispensed as written (DAW);

(b) The pharmacist dispenses the nonpreferred drug as prescribed; and

(c) The department does not require prior authorization to dispense the nonpreferred drug in place of a preferred drug except when the drug requires authorization for safety.

(6) In the event the following therapeutic drug classes are on the Washington PDL, pharmacists will not substitute a preferred drug for a nonpreferred drug in these therapeutic drug classes when the endorsing practitioner prescribes a refill (including the renewal of a previous prescription or adjustments in dosage, and samples):

(a) Antipsychotic;

(b) Antidepressant;

(c) Chemotherapy;

(d) Antiretroviral;

(e) Immunosuppressive; or

(f) Immunomodulator/antiviral treatment for hepatitis C

for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-4150, filed 9/26/07, effective 11/1/07.]

WAC 388-530-5000 Billing requirements—Pharmacy claim payment. (1) When billing the department for pharmacy services, providers must:

(a) Use the appropriate department claim form or electronic billing specifications;

(b) Include the actual eleven-digit national drug code (NDC) number of the product dispensed from a rebate eligible manufacturer;

(c) Bill the department using metric decimal quantities which is the National Council for Prescription Drug Programs (NCPDP) billing unit standard;

(d) Meet the general provider documentation and record retention requirements in WAC 388-502-0020; and

(e) Maintain proof of delivery receipts.

(i) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be

able to furnish proof of delivery including signature, client's name and a detailed description of the item(s) delivered.

(ii) When a provider mails an item to the client, the provider must be able to furnish proof of delivery including a mail log.

(iii) When a provider uses a delivery/shipping service to deliver items, the provider must be able to furnish proof of delivery and it must:

(A) Include the delivery service tracking slip with the client's name or a reference to the client's package(s); the delivery service package identification number; and the delivery address.

(B) Include the supplier's shipping invoice, with the client's name; the shipping service package identification number; and a detailed description(s).

(iv) Make proof of delivery receipts available to the department, upon request.

(2) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code(s) in the appropriate data field on the drug claim.

(3) Pharmacy services for clients on restriction under WAC 388-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

- (a) Emergency;
- (b) Family planning services; or
- (c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-5000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-5050 Billing requirements—Point-of-sale (POS) system/prospective drug use review (Pro-DUR). (1) Pharmacy claims for drugs and other products listed in the department's drug file and billed to the department by national drug code (NDC) are adjudicated by the department's point-of-sale (POS) system. Claims must be submitted for payment using the billing unit standard identified in WAC 388-530-5000.

(2) All pharmacy drug claims processed through the POS system undergo a system-facilitated prospective drug use review (Pro-DUR) screening as a complement to the Pro-DUR screening required of pharmacists.

(3) If the POS system identifies a potential drug therapy problem during Pro-DUR screening, a message will alert the pharmacy provider indicating the type of potential problem. The alerts regarding possible drug therapy problems include, but are not limited to:

- (a) Therapeutic duplication;
- (b) Duration of therapy exceeds the recommended maximum period;
- (c) Drug-to-drug interaction;
- (d) Drug disease precaution;
- (e) High dose;
- (f) Ingredient duplication;
- (g) Drug-to-client age conflict;
- (h) Drug-to-client gender conflict; or
- (i) Refill too soon.

(4) The department provides pharmacy providers with a list of codes from which to choose in overriding POS system

alert messages. These codes come from the national council for prescription drug programs (NCPDP).

(5) The dispensing pharmacist evaluates the potential drug therapy conflict and enters applicable NCPDP codes representing their professional interaction.

(a) If the resolution to the conflict satisfies department requirements, the claim will be processed accordingly.

(b) If the resolution to the conflict does not satisfy department requirements, the department requires prior authorization. This includes all claims for which an alert message is triggered in the POS system and an NCPDP override code is not appropriate.

(6) The department requires providers to retain documentation of the justification for the use of payment system override codes as described in subsections (4) and (5) of this section. The department requires the documentation be retained for the same period as that described in WAC 388-502-0020.

(7) POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-5050, filed 9/26/07, effective 11/1/07.]

WAC 388-530-5100 Billing requirements—Unit dose. (1) To be eligible for a unit dose dispensing fee from the department, a pharmacy must:

- (a) Notify the department in writing of its intent to provide unit dose service;
- (b) Identify the nursing facility(ies) to be served;
- (c) Indicate the approximate date unit dose service to the facility(ies) will commence; and
- (d) Follow department requirements for unit dose payment.

(2) Under a unit dose delivery system, a pharmacy must bill only for the number of drug units actually used by the medical assistance client in the nursing facility, except as provided in subsections (3), (4), and (5) of this section. It is the unit dose pharmacy provider's responsibility to coordinate with nursing facilities to ensure that the unused drugs the pharmacy dispensed to clients are returned to the pharmacy for credit.

(3) The pharmacy must submit an adjustment form or claims reversal of the charge to the department for the cost of all unused drugs returned to the pharmacy from the nursing facility on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (5) of this section. Such adjustment must conform to the nursing facility's monthly log as described in subsection (7) of this section.

(4) The department pays a unit dose provider a dispensing fee when a provider-packaged unit dose prescription is returned, in its entirety, to the pharmacy. A dispensing fee is not paid if the returned prescription is for a drug with a manufacturer-designated unit dose national drug code (NDC). In addition to the dispensing fee paid under this subsection, the provider may bill the department one unit of the tablet or capsule but must credit the department for the remainder of the ingredient costs for the returned prescription.

(5) Unit dose providers do not have to credit the department for federally designated schedule two drugs which are

returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

(6) Pharmacies must not charge clients or the department a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's drug delivery system; or

(b) For the nursing facility's convenience.

(7) The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility served, including but not limited to the following information:

- (a) Facility name and address;
- (b) Client's name and patient identification code (PIC);
- (c) Drug name/strength;
- (d) National drug code (NDC);
- (e) Quantity and date dispensed;
- (f) Quantity and date returned;
- (g) Value of returned drugs or amount credited;
- (h) Explanation for no credit given or nonreusable returns; and
- (i) Prescription number.

(8) Upon the department's request, the pharmacy must submit copies of the logs referred to in subsection (7) of this section.

(9) When the pharmacy submits the completed annual prescription volume survey to the department, it must include an updated list of all nursing facilities currently served under unit dose systems.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-5100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-6000 Mail-order services. The department provides a contracted mail-order pharmacy service for client use. The mail-order contractor is selected as a result of a competitive procurement process.

(1) The contracted mail-order pharmacy service is available as an option to all medical assistance clients, subject to the:

- (a) Scope of the client's medical care program;
- (b) Availability of services from the contracted mail-order provider; and
- (c) Special terms and conditions described in subsection (2) and (3) of this section.

(2) The mail-order prescription service may not dispense medication in a quantity greater than authorized by the prescriber. (See RCW 18.64.360(5), Nonresident pharmacies.)

(3) Prescribed medications may be filled by the mail-order pharmacy service within the following restrictions:

(a) Drugs available from mail-order in no more than a ninety day supply include:

- (i) Preferred drugs (see WAC 388-530-4100);
- (ii) Generic drugs; and
- (iii) Drugs that do not have authorization requirements (see WAC 388-530-3000 through WAC 388-530-3200).

(b) Drugs available in no more than a thirty-four-day supply:

- (i) Controlled substances (schedules II through V); and

(ii) Drugs having authorization requirements (see WAC 388-530-3000).

(c) Other pharmacy restrictions (chapter 388-530 WAC, Pharmacy services) continue to apply.

(4) The contracted mail-order pharmacy services are reimbursed at levels lower than those established for the regular outpatient pharmacy services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-6000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7000 Reimbursement. (1) The department's total reimbursement for a prescription drug must not exceed the lowest of:

- (a) Estimated acquisition cost (EAC) plus a dispensing fee;
- (b) Maximum allowable cost (MAC) plus a dispensing fee;
- (c) Federal upper limit (FUL) plus a dispensing fee;
- (d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340B of the Public Health Service (PHS) Act;
- (e) Automated maximum allowable cost (AMAC) plus a dispensing fee; or
- (f) The provider's usual and customary charge to the non-Medicaid population.

(2) The department selects the sources for pricing information used to set EAC and MAC.

(3) The department may solicit assistance from pharmacy providers, pharmacy benefit managers (PBM), other government agencies, actuaries, and/or other consultants when establishing EAC and/or MAC.

(4) The department reimburses a pharmacy for the least costly dosage form of a drug within the same route of administration, unless the prescriber has designated a medically necessary specific dosage form or the department has selected the more expensive dosage form as a preferred drug.

(5) If the pharmacy provider offers a discount, rebate, promotion or other incentive which directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to the department for the prescription.

(6) If the pharmacy provider gives an otherwise covered product for free to the general public, the pharmacy must not submit a claim to the department.

(7) The department does not reimburse for:

- (a) Prescriptions written on presigned prescription blanks filled out by nursing facility operators or pharmacists;
- (b) Prescriptions without the date of the original order;
- (c) Drugs used to replace those taken from a nursing facility emergency kit;
- (d) Drugs used to replace a physician's stock supply;
- (e) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:
 - (i) Diagnosis-related group (DRG);
 - (ii) Ratio of costs-to-charges (RCC);
 - (iii) Nursing facility daily rates;
 - (iv) Managed care capitation rates;
 - (v) Block grants; or

(vi) Drugs prescribed for clients who are on the department's hospice program when the drugs are related to the client's terminal illness and related condition.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7050 Reimbursement—Dispensing fee determination. (1) Subject to the provisions of WAC 388-530-7000 and the exceptions permitted in WAC 388-530-2000, the department pays a dispensing fee for each covered, prescribed drug.

(2) The department does not pay a dispensing fee for nondrug items, devices, or drug-related supplies.

(3) The department adjusts the dispensing fee by considering factors including, but not limited to:

- (a) Legislative appropriations for vendor rates;
- (b) Input from provider and/or advocacy groups;
- (c) Input from state-employed or contracted actuaries;

and

(d) Dispensing fees paid by other third-party payers, including, but not limited to, health care plans and other states' Medicaid agencies.

(4) The department uses a tiered dispensing fee system which pays higher volume pharmacies at a lower fee and lower volume pharmacies at a higher fee.

(5) The department uses total annual prescription volume (both Medicaid and non-Medicaid) reported to the department to determine each pharmacy's dispensing fee tier.

(a) A pharmacy which fills more than thirty-five thousand prescriptions annually is a high-volume pharmacy. The department considers hospital-based pharmacies that serve both inpatient and outpatient clients as high-volume pharmacies.

(b) A pharmacy which fills between fifteen thousand one and thirty-five thousand prescriptions annually is a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually is a low-volume pharmacy.

(6) The department determines a pharmacy's annual total prescription volume as follows:

(a) The department sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies return completed prescription volume surveys to the department each year. Pharmacy providers not responding to the survey by the specified date are assigned to the high volume category;

(c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count;

(d) The department considers prescriptions dispensed to nursing facility clients as outpatient prescriptions; and

(e) Assignment to a new dispensing fee tier is effective on the first of the month, following the date specified by the department.

(7) A pharmacy may request a change in dispensing fee tier during the interval between the annual prescription volume surveys. The pharmacy must substantiate such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for the new tier. If the department receives the doc-

umentation by the twentieth of the month, assignment to a new dispensing fee tier is effective on the first of the following month.

(8) The department grants general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume).

(9) The department may pay true unit dose pharmacies at a different rate for unit dose dispensing.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7050, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7100 Reimbursement—Pharmaceutical supplies. (1) The department reimburses for selected pharmaceutical supplies through the pharmacy point-of-sale (POS) system when it is necessary for client access and safety.

(2) The department bases reimbursement of pharmaceutical items or supplies that are not payable through the POS on department-published fee schedules.

(3) The department uses any or all of the following methodologies to set the maximum allowable reimbursement rate for drugs, devices, and drug-related supplies:

(a) A pharmacy provider's acquisition cost. Upon review of the claim, the department may require an invoice which must show the name of the item, the manufacturer, the product description, the quantity, and the current cost including any free goods associated with the invoice;

(b) Medicare's reimbursement rate for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

(4) The department does not pay a dispensing fee for nondrug items, devices, or drug-related supplies. See WAC 388-530-7050.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7150 Reimbursement—Compounded prescriptions. (1) The department does not consider reconstitution to be compounding.

(2) The department covers a drug ingredient used for a compounded prescription only when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services (DHHS).

(3) The department considers bulk chemical supplies used in compounded prescriptions as nondrug items, which do not require a drug rebate agreement. The department covers such bulk chemical supplies only as specifically approved by the department.

(4) The department reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

(a) The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

(b) The pharmacist must ensure that the ingredients used in a compounded prescription are for an approved use as defined in "medically accepted indication" in WAC 388-530-1050.

(5) The department requires that each drug ingredient used for a compounded prescription be billed to the department using its eleven-digit national drug code (NDC) number.

(6) Compounded prescriptions are reimbursed as follows:

(a) The department allows only the lowest cost for each covered ingredient, whether that cost is determined by actual acquisition cost (AAC), estimated acquisition cost (EAC), federal upper limit (FUL), maximum allowable cost (MAC), automated maximum allowable cost (AMAC), or amount billed.

(b) The department applies current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under subsection (6)(c) of this section. The department denies payment for a drug requiring authorization when authorization is not obtained.

(c) The department may designate selected drugs as not requiring authorization when used for compounded prescriptions. For the list of selected drugs, refer to the department's prescription drug program billing instructions.

(d) The department pays a dispensing fee as described under WAC 388-530-7050 for each drug ingredient used in compounding when the conditions of this section are met and each ingredient is billed separately by the eleven digit NDC.

(e) The department does not pay a separate fee for compounding time.

(7) The department requires pharmacists to document the need for each inactive ingredient added to the compounded prescription. The department limits reimbursement to the inactive ingredients that meet the following criteria. To be reimbursed by the department, each inactive ingredient must be:

- (a) A necessary component of a compounded drug; and
- (b) Billed by an eleven digit national drug code (NDC).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-7150, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7200 Reimbursement—Out-of-state prescriptions. (1) The department reimburses out-of-state pharmacies for prescription drugs provided to an eligible client within the scope of the client's medical care program if the pharmacy:

- (a) Contracts with the department to be an enrolled provider; and
 - (b) Meets the same criteria the department requires for in-state pharmacy providers.
- (2) The department considers pharmacies located in bordering areas listed in WAC 388-501-0175 the same as in-state pharmacies.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-7200, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7250 Reimbursement—Miscellaneous. The department reimburses for covered drugs, devices, and drug-related supplies provided or administered by nonpharmacy providers under specified conditions, as follows:

(1) The department reimburses for drugs administered or prepared and delivered for individual use by an authorized

prescriber during an office visit according to specific program rules found in:

- (a) Chapter 388-531 WAC, Physician-related services;
- (b) Chapter 388-532 WAC, Reproductive health/family planning only/TAKE CHARGE; and
- (c) Chapter 388-540 WAC, Kidney services.

(2) Providers who are purchasers of Public Health Services (PHS) discounted drugs must comply with PHS 340b program requirements. (See WAC 388-530-7900).

(3) The department may request providers to submit a current invoice for the actual cost of the drug, device, or drug-related supply billed. If an invoice is requested, the invoice must show the:

- (a) Name of the drug, device, or drug-related supply;
- (b) Drug or product manufacturer;
- (c) NDC of the product(s);
- (d) Drug strength;
- (e) Product description;
- (f) Quantity; and
- (g) Cost, including any free goods associated with the invoice.

(4) The department does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH). The department does pay physicians, advanced registered nurse practitioners (ARNP), and pharmacists a fee for administering the vaccine.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-7250, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7300 Reimbursement—Requesting a change. Upon request from a pharmacy provider, the department may reimburse at actual acquisition cost (AAC) for a drug that would otherwise be reimbursed at maximum allowable cost (MAC) when:

- (1) The availability of lower cost equivalents in the marketplace is severely curtailed and the price disparity between AAC for the drug and the MAC reimbursement affects clients' access; and
- (2) An invoice documenting actual acquisition cost relevant to the date the drug was dispensed is provided to the department.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-7300, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7350 Reimbursement—Unit dose drug delivery systems. (1) The department pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (7) and (8) of this section.

(2) Unit dose delivery systems may be either true or modified unit dose.

(3) The department pays pharmacies that provide unit dose delivery services the department's highest allowable dispensing fee for each unit dose prescription dispensed to clients in nursing facilities. The department reimburses ingredient costs for drugs under unit dose systems as described in WAC 388-530-7000.

(4) The department pays a pharmacy that dispenses drugs in bulk containers or multidose forms to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume tier. Drugs the

department considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. The department reimburses ingredient costs as described in WAC 388-530-7000.

(5) The department pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable under WAC 388-530-7050. The department reimburses ingredient costs for drugs prepackaged by the manufacturer in unit dose form as described in WAC 388-530-7000.

(6) The department limits its coverage and payment for manufacturer-designated unit dose packaging to the following conditions:

(a) The drug is a single source drug and a multidose package for the drug is not available;

(b) The drug is a multiple source drug but there is no other multidose package available among the drug's generic equivalents; or

(c) The manufacturer-designated unit dose package is the most cost-effective package available or it is the least costly alternative form of the drug.

(7) The department reimburses a pharmacy provider for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise be covered as an outpatient drug. The unit dose dispensing fee does not apply in such cases. The department pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(8) The department may pay for unit dose delivery systems for clients of the division of developmental disabilities (DDD) residing in approved community living arrangements.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-7350, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7400 Reimbursement—Compliance packaging services. (1) The department reimburses pharmacies for compliance packaging services provided to clients considered at risk for adverse drug therapy outcomes. Clients who are eligible for compliance packaging services must not reside in a nursing home or other inpatient facility, and must meet (a) and either (b) or (c) of this subsection. The client must:

(a) Have one or more of the following representative disease conditions:

- (i) Alzheimer's disease;
- (ii) Blood clotting disorders;
- (iii) Cardiac arrhythmia;
- (iv) Congestive heart failure;
- (v) Depression;
- (vi) Diabetes;
- (vii) Epilepsy;
- (viii) HIV/AIDS;
- (ix) Hypertension;
- (x) Schizophrenia; or
- (xi) Tuberculosis.

(b) Concurrently consume two or more prescribed medications for chronic medical conditions, that are dosed at three or more intervals per day; or

(c) Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

(2) Compliance packaging services include:

(a) Reusable hard plastic containers of any type (e.g., medisets); and

(b) Nonreusable compliance packaging devices (e.g., blister packs).

(3) The department pays a filling fee and reimburses pharmacies for the compliance packaging device and/or container. The frequency of fills and number of payable compliance packaging devices per client is subject to limits specified by the department. The department does not pay filling or preparation fees for blister packs.

(4) Pharmacies must use the CMS-1500 claim form to bill the department for compliance packaging services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-7400, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7500 Drug rebate requirement. (1) The department reimburses for outpatient prescription drugs only when they are supplied by manufacturers who have a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS), according to 42 U.S.C.1396r-8. The manufacturer must be listed on the list of participating manufacturers as published by CMS.

(2) The fill date must be within the manufacturer's beginning and ending eligibility dates to be reimbursed by the department.

(3) The department may extend this rebate requirement to any outpatient drug reimbursements as allowed or required by federal law.

(4) The department may exempt drugs from the rebate requirement, on a case-by-case basis, when:

(a) It determines that the availability of a single source drug or innovator multiple source drug is essential to the health of beneficiaries; and

(b) All other rebate exemption requirements of SSA Sec 1927 (42 U.S.C.1396r-8) (3) are also satisfied.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-7500, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7600 Reimbursement—Clients enrolled in managed care. Except as specified under the department's managed care contracts, the department does not reimburse providers for any drugs or pharmaceutical supplies provided to clients who have pharmacy benefits under department-contracted managed care plans. The managed care plan is responsible for payment.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 07-20-049, § 388-530-7600, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7700 Reimbursement—Dual eligible clients/Medicare. For clients who are dually eligible for medical assistance and Medicare benefits, the following applies:

(1) Medicare Part B, the department pays providers for:

(a) An amount up to the department's maximum allowable fee for drugs Medicare does not cover, but the department covers; or

(b) Deductible and/or coinsurance amounts up to Medicare's or the department's maximum allowable fee, whichever is less, for drugs Medicare and the department cover; or

(c) Deductible and/or coinsurance amounts for clients under the qualified Medicare beneficiary (QMB) program for drugs Medicare covers but the department does not cover.

(2) Medicare Part D:

(a) For payment of Medicare Part D drugs:

(i) Medicare is the primary payer for covered Part D drugs;

(ii) The department pays only the copayment up to a maximum amount set by the Centers for Medicare and Medicaid Services (CMS); and

(iii) The client is responsible for copayments above the maximum amount.

(b) For drugs excluded from the basic Medicare Part D benefits:

(i) The department offers the same drug benefit as a non-dual eligible client has within those same classes;

(ii) If the client has another third party insurer, that insurer is the primary payer; and

(iii) The department is the payer of last resort.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7700, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7800 Reimbursement—Clients with third-party liability. (1) The department requires providers to meet the third party requirements of WAC 388-501-0200.

(2) The following definitions apply to this section:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the department's POS system, which requires that coverage be verified by or submitted to the insurer for authorization at the time of service and at the time the prescription is filled.

(3) This subsection applies to clients who have a third-party resource that is a managed care entity other than a department-contracted plan, or have other insurance that requires the use of "closed pharmacy networks" or "private point-of-sale authorization system." The department will not pay pharmacies for prescription drug claims until the pharmacy provider submits an explanation of benefits from the private insurance demonstrating that the pharmacy provider has complied with the terms of the third-party's coverage.

(a) If the private insurer pays a fee based on the incident of care, the pharmacy provider must file a claim with the department consistent with the department's billing requirements.

(b) If the private insurer pays the pharmacy provider a monthly capitation fee for all prescription costs related to the client, the pharmacy provider must submit a claim to the department for the amount of the client copayment, coinsurance, and/or deductible. The department pays the provider the lesser of:

(i) The billed amount; or

(ii) The department's maximum allowable fee for the prescription.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7800, filed 9/26/07, effective 11/1/07.]

WAC 388-530-7900 Drugs purchased under the Public Health Service (PHS) Act. (1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities and must be billed to the department at actual acquisition cost (AAC) as required by laws governing the PHS 340B program.

(2) Providers dispensing drugs under this section are required to submit their valid medical assistance provider number(s) to the PHS health resources and services administration, office of pharmacy affairs. This requirement is to ensure that claims for drugs dispensed under this section and paid by the department are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs. See WAC 388-530-7500 for information on the drug rebate program.

(3) The department reimburses drugs under this section at actual acquisition cost plus a dispensing fee set by the department.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-7900, filed 9/26/07, effective 11/1/07.]

WAC 388-530-8000 Reimbursement method—Estimated acquisition cost (EAC). (1) The department determines estimated acquisition cost (EAC) using:

(a) Acquisition cost data made available to the department; or

(b) Information provided by any of the following:

(i) Audit agencies, federal or state;

(ii) Other state health care purchasing agencies;

(iii) Pharmacy benefit managers;

(iv) Individual pharmacy providers participating in the department's programs;

(v) Centers for Medicare and Medicaid Services (CMS);

(vi) Other third party payers;

(vii) Drug file data bases; and/or

(viii) Actuaries or other consultants.

(2) The department implements EAC by applying a percentage adjustment to available reference pricing from national sources such as wholesale acquisition cost (WAC), average wholesale price (AWP), average sale price (ASP), and average manufacturer price (AMP).

(3) The department may set EAC for specified drugs or drug categories at a percentage other than that determined in subsection (1)(a) of this section when the department considers it necessary. The factors the department considers in setting a rate for a class of drugs under this subsection include, but are not limited to:

(a) Product acquisition cost;

(b) The department's documented clinical concerns; and

(c) The department's budget limits.

(4) The department bases EAC drug reimbursement on the actual package size dispensed.

(5) The department uses the EAC as the department's reimbursement for a drug when the EAC is the lowest of the

rates calculated under the methods listed in WAC 388-530-7000, or when the conditions of WAC 388-530-7300 are met.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-8000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-8050 Reimbursement—Federal upper limit (FUL). (1) The department adopts the federal upper limit (FUL) set by the Centers for Medicare and Medicaid Services (CMS).

(2) The department's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by the department.

(3) Except as provided in WAC 388-530-7300, the department uses the FUL as the department's reimbursement rate for the drug when the FUL price is the lowest of the rates calculated under the methods listed in WAC 388-530-7000.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-8050, filed 9/26/07, effective 11/1/07.]

WAC 388-530-8100 Reimbursement—Maximum allowable cost (MAC). (1) The department establishes a maximum allowable cost (MAC) for a multiple-source drug which is available from at least two manufacturers/labelers.

(2) The department determines the MAC for a multiple-source drug:

(a) When specific regional and local drug acquisition cost data is available, the department:

(i) Identifies what products are available from wholesalers for each drug being considered for MAC pricing;

(ii) Determines pharmacy providers' approximate acquisition costs for these products; and

(iii) Establishes the MAC at a level which gives pharmacists access to at least one product from a manufacturer with a qualified rebate agreement (see WAC 388-530-7500(4)).

(b) When specific regional and local drug acquisition cost data is not available, the department may estimate acquisition cost based on national pricing sources.

(3) The MAC established for a multiple-source drug does not apply if the written prescription identifies that a specific brand is medically necessary for a particular client. In such cases, the estimated acquisition cost (EAC) for the particular brand applies, provided authorization is obtained from the department as specified under WAC 388-530-3000.

(4) Except as provided in subsection (3) of this section, the department reimburses providers for a multiple-source drug at the lowest of the rates calculated under the methods listed in WAC 388-530-7000.

(5) The MAC established for a multiple-source drug may vary by package size, including those identified as unit dose national drug codes (NDCs) by the manufacturer(s) of the drug.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-8100, filed 9/26/07, effective 11/1/07.]

WAC 388-530-8150 Reimbursement—Automated maximum allowable cost (AMAC). (1) The department uses the automated maximum allowable cost (AMAC) pricing methodology for multiple-source drugs that are:

(a) Not on the published maximum allowable cost (MAC); and

(b) Produced by two or more manufacturers/labelers, at least one of which must have a current, signed federal drug rebate agreement.

(2) The department establishes AMAC as a specified percentage of the published average wholesale price (AWP) or other nationally accepted pricing source in order to estimate acquisition cost.

(3) The department sets the percentage discount from AWP for AMAC reimbursement using any of the information sources identified in WAC 388-530-8000.

(4) The department may set AMAC reimbursement at different percentage discounts from AWP for different multiple source drugs. The department considers the same factors as those in WAC 388-530-8000.

(5) AMAC reimbursement for all products with the same ingredient, form and strength is at the AMAC determined for the second lowest priced product, or the AMAC of the lowest priced drug from a manufacturer with a current, signed federal rebate agreement.

(6) The department recalculates AMAC each time the drug file contractor provides a pricing update.

(7) Except as provided in WAC 388-530-7300, the department reimburses at the lowest of the rates calculated under the methods listed in WAC 388-530-7000.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700.07-20-049, § 388-530-8150, filed 9/26/07, effective 11/1/07.]

Chapter 388-535 WAC DENTAL-RELATED SERVICES

WAC

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|--------------|---|--------------|--|
| 388-535-1259 | Covered dental-related services for clients age twenty-one and older—Restorative services. | | filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. |
| 388-535-1261 | Covered dental-related services for clients age twenty-one and older—Endodontic services. | 388-535-1290 | Dentures and partial dentures for adults. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1290, filed 9/12/03, effective 10/13/03.] Repealed by 07-06-041, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. |
| 388-535-1263 | Covered dental-related services for clients age twenty-one and older—Periodontic services. | | |
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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| 388-535-1200 | Dental-related services requiring prior authorization—Children. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1200, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1200, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1200, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.] Repealed by 07-06-042, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. | | |
| 388-535-1230 | Crowns for children. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1230, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1230, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520. 01-07-077, § 388-535-1230, filed 3/20/01, effective 4/20/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1230, filed 3/10/99, effective 4/10/99.] Repealed by 07-06-042, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. | | |
| 388-535-1240 | Dentures, partial dentures, and overdentures for children. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1240, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1240, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1240, filed 3/10/99, effective 4/10/99.] Repealed by 07-06-042, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. | | |
| 388-535-1265 | Dental-related services not covered—Adults. [Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-535-1265, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1265, filed 9/12/03, effective 10/13/03.] Repealed by 07-14-031, filed 6/26/07, effective 7/27/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. Later promulgation, see WAC 388-535-1271. | | |
| 388-535-1270 | Dental-related services requiring prior authorization—Adults. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1270, filed 9/12/03, effective 10/13/03.] Repealed by 07-06-041, | | |

WAC 388-535-1050 Dental-related definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. The department also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Anterior" refers to teeth (maxillary and mandibular incisors and canines) and tissue in the front of the mouth. Permanent maxillary anterior teeth include teeth six, seven, eight, nine, ten, and eleven. Permanent mandibular anterior teeth include teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven. Primary maxillary anterior teeth include teeth C, D, E, F, G, and H. Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

"Asymptomatic" means having or producing no symptoms.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

"By report" - a method of reimbursement in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Caries" means carious lesions or tooth decay through the enamel or decay of the root surface.

"Comprehensive oral evaluation" means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

"Conscious sedation" is a drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a

patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

"Core buildup" refers to building up of clinical crowns, including pins.

"Coronal" is the portion of a tooth that is covered by enamel.

"Coronal polishing" is a mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

"Crown" means a restoration covering or replacing part or the whole clinical crown of a tooth.

"Current dental terminology (CDT)" is a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)" is a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Decay" is a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" is a drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

"Dental general anesthesia" see **"general anesthesia."**

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Denturist" means a person licensed under chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

"Endodontic" means the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

"EPSDT" means the department's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Extraction" see **"simple extraction"** and **"surgical extraction."**

"Flowable composite" is a diluted resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

"Fluoride varnish, rinse, foam or gel" is a substance containing dental fluoride which is applied to teeth.

"General anesthesia" is a drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"High noble metal" is a dental alloy containing at least sixty percent pure gold.

"Limited oral evaluation" is an evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

"Limited visual oral assessment" is an assessment by a dentist or dental hygienist to determine the need for fluoride treatment and/or when triage services are provided in settings other than dental offices or dental clinics.

"Major bone grafts" is a transplant of solid bone tissue(s).

"Medically necessary" see WAC 388-500-0005.

"Minor bone grafts" is a transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

"Noble metal" is a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Oral evaluation" see **"comprehensive oral evaluation."**

"Oral hygiene instruction" means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

"Oral prophylaxis" is the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from teeth.

"Partials" or **"partial dentures"** are a removable prosthetic appliance that replaces missing teeth in one arch.

"Periodic oral evaluation" is an evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation.

"Periodontal maintenance" is a procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival microorganisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Periodontal scaling and root planing" is a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Posterior" refers to the teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth. Permanent maxillary posterior teeth include teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen. Permanent mandibular posterior teeth include teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Proximal" is the surface of the tooth near or next to the adjacent tooth.

"Radiograph" is an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

"Reline" means to resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

"Root canal" is the chamber within the root of the tooth that contains the pulp.

"Root canal therapy" is the treatment of the pulp and associated periradicular conditions.

"Root planing" is a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation.

"Scaling" is a procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

"Sealant" is a dental material applied to teeth to prevent dental caries.

"Simple extraction" is the routine removal of a tooth.

"Standard of care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

"Surgical extraction" is the removal of a tooth by cutting of the gingiva and bone. This includes soft tissue extractions, partial boney extractions, and complete boney extractions.

"Symptomatic" means having symptoms (e.g., pain, swelling, and infection).

"Temporomandibular joint dysfunction (TMJ/TMD)" is an abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

"Therapeutic pulpotomy" is the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill the department.

"Wisdom teeth" are the third molars, teeth one, sixteen, seventeen, and thirty-two.

"Xerostomia" is a dryness of the mouth due to decreased saliva.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-17-107, § 388-535-1065, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, and 74.09.530, 04-14-100, § 388-535-1050, filed 7/6/04, effective 8/6/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-077, § 388-535-1050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1050, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 01-02-076, § 388-535-1050, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1065 Coverage limits for dental-related services provided under the GA-U and ADATSA programs. (1) Clients who receive medical care services under the following programs may receive the dental-related services described in this section:

(a) General assistance unemployable (GA-U); and
(b) Alcohol and drug abuse treatment and support act (ADATSA).

(2) The department covers the following dental-related services for a client eligible under the GA-U or ADATSA program:

(a) Services provided only as part of dental treatment for:
(i) Limited oral evaluation;

(ii) Periapical or bite-wing radiographs that are medically necessary to diagnose only the client's chief complaint;
(iii) Palliative treatment to relieve dental pain;
(iv) Pulpal debridement to relieve dental pain; or
(v) Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized).

(b) Tooth extraction when at least one of the following apply:

(i) The tooth has a radiograph apical lesion;
(ii) The tooth is endodontically involved, infected, or abscessed;
(iii) The tooth is not restorable; or
(iv) The tooth is not periodontally stable.

(3) Tooth extractions require prior authorization when:

(i) The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and

(ii) A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

(4) Each dental-related procedure described under this section is subject to the coverage limitations listed in chapter 388-535 WAC.

(5) The department does not cover any dental-related services not listed in this section for clients eligible under the GA-U or ADATSA program, including any type of removable prosthesis (denture).

[Statutory Authority: RCW 74.04.050, 74.08.090, 07-17-107, § 388-535-1065, filed 8/17/07, effective 9/17/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1065, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, and 74.09.530, 04-14-100, § 388-535-1065, filed 7/6/04, effective 8/6/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-077, § 388-535-1065, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1079 Dental-related services for clients through age twenty—General. (1) Subject to coverage limitations, the department pays for dental-related services and procedures provided to clients through age twenty when the services and procedures:

(a) Are within the scope of an eligible client's medical care program;

(b) Are medically necessary;

(c) Meet the department's prior authorization requirements, if any;

(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

(e) Are within accepted dental or medical practice standards;

(f) Are consistent with a diagnosis of dental disease or condition;

(g) Are reasonable in amount and duration of care, treatment, or service; and

(h) Are listed as covered in the department's published rules, billing instructions and fee schedules.

(2) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients ages twenty and younger may be eligible for dental-related services listed as noncovered.

(3) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services according to WAC 388-535-1099.

(4) The department evaluates a request for dental-related services:

(a) That are in excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and

(b) That are listed as noncovered according to WAC 388-501-0160.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1079, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1080 Covered dental-related services for clients through age twenty—Diagnostic. The department covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Clinical oral evaluations.** The department covers:

(a) Oral health evaluations and assessments.

(b) Periodic oral evaluations as defined in WAC 388-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(c) Limited oral evaluations as defined in WAC 388-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The department does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC 388-535-1050, once per client, per provider or clinic, as an initial examination. The department covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(e) Limited visual oral assessments as defined in WAC 388-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services;

(ii) Performed to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(2) **Radiographs (X rays).** The department:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The department requires original radiographs to be retained by the provider as part of the client's dental record, and duplicate radiographs to be submitted with prior authorization requests, or when copies of dental records are requested.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series (includes four bitewings), once in a three-year period only if the department

has not paid for a panoramic radiograph for the same client in the same three-year period.

(d) Covers periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be included in the client's record.

(e) Covers an occlusal intraoral radiograph once in a two-year period. Documentation supporting the medical necessity for these must be included in the client's record.

(f) Covers a maximum of four bitewing radiographs once every twelve months for clients through age eleven.

(g) Covers a maximum of four bitewing radiographs once every twelve months for clients ages twelve through twenty.

(h) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the department has not paid for an intraoral complete series for the same client in the same three-year period.

(i) May cover panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized.

(j) Covers cephalometric film:

(i) For orthodontics, as described in chapter 388-535A WAC; or

(ii) Only on a case-by-case basis and when prior authorized.

(k) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(l) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the department.

(3) **Tests and examinations.** The department covers:

(a) One pulp vitality test per visit (not per tooth):

(i) For diagnosis only during limited oral evaluations; and

(ii) When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

(b) Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the department.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1080, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-078, § 388-535-1080, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1080, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1082 Covered dental-related services for clients through age twenty—Preventive services. The department covers medically necessary dental-related preventive services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Dental prophylaxis.** The department covers prophylaxis:

(a) Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary, transitional, or permanent dentition, once every six months for clients through age twenty.

(b) Only when the service is performed six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ages thirteen through twenty.

(c) Only when not performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy or gingivoplasty.

(d) For clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Topical fluoride treatment.** The department covers:

(a) Fluoride varnish, rinse, foam or gel for clients ages six and younger, up to three times within a twelve-month period.

(b) Fluoride varnish, rinse, foam or gel for clients ages seven through eighteen, up to two times within a twelve-month period.

(c) Fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period during orthodontic treatment.

(d) Fluoride rinse, foam or gel for clients ages nineteen through twenty, once within a twelve-month period.

(e) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(f) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Oral hygiene instruction.** The department covers:

(a) Oral hygiene instruction only for clients through age eight.

(b) Oral hygiene instruction up to two times within a twelve-month period.

(c) Individualized oral hygiene instruction for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.

(d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.

(e) Oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

(4) **Sealants.** The department covers:

(a) Sealants only when used on a mechanically and/or chemically prepared enamel surface.

(b) Sealants once per tooth in a three-year period for clients through age eighteen.

(c) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(d) Sealants on noncarious teeth or teeth with incipient caries.

(e) Sealants only when placed on a tooth with no pre-existing occlusal restoration, or any occlusal restoration placed on the same day.

(f) Additional sealants on a case-by-case basis and when prior authorized.

(5) **Space maintenance.** The department covers:

(a) Fixed unilateral or fixed bilateral space maintainers for clients through age eighteen.

(b) Only one space maintainer per quadrant.

(c) Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.

(d) Replacement space maintainers only on a case-by-case basis and when prior authorized.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1082, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1084 Covered dental-related services for clients through age twenty—Restorative services. The department covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Restorative/operative procedures.** The department covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

(a) Clients ages eight and younger;

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Amalgam restorations for primary and permanent teeth.** The department considers:

(a) Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.

(b) The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.

(c) Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers one buccal and one lingual surface per tooth.

(d) Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.

(e) Amalgam restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(3) **Amalgam restorations for primary posterior teeth only.** The department covers amalgam restorations for a maximum of two surfaces for a primary first molar and maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this section for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional amalgam restorations.

(4) **Amalgam restorations for permanent posterior teeth only.** The department:

(a) Covers two occlusal amalgam restorations for teeth one, two, three, fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure.

(b) Covers amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

(c) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) Does not pay for replacement of amalgam restoration on permanent posterior teeth within a two-year period unless the restoration has an additional adjoining carious surface. The department pays for the replacement restoration as one multi-surface restoration. The client's record must include

radiographs and documentation supporting the medical necessity for the replacement restoration.

(5) Resin-based composite restorations for primary and permanent teeth. The department:

(a) Considers tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.

(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants (see WAC 388-535-1082(4) for sealants coverage).

(e) Considers multiple preventive restorative resin, flowable composite resin, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.

(f) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial and/or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

(g) Considers resin-based composite restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(6) Resin-based composite restorations for primary teeth only. The department covers:

(a) Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth (see subsection (9)(b) of this section for restorations for a primary anterior tooth requiring a four or more surface restoration). The department does not pay for additional composite or amalgam restorations on the same tooth after three surfaces.

(b) Resin-based composite restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this subsection for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional composite restorations on the same tooth.

(c) Glass ionomer restorations only for primary teeth, and only for clients ages five and younger. The department pays for these restorations as a one surface resin-based composite restoration.

(7) Resin-based composite restorations for permanent teeth only. The department covers:

(a) Two occlusal resin-based composite restorations for teeth one, two, fourteen, fifteen, and sixteen if the restorations are anatomically separated by sound tooth structure.

(b) Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

(c) Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) Resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period.

(e) Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. The department pays the replacement restoration as a one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(8) Crowns. The department:

(a) Covers the following crowns once every five years, per tooth, for permanent anterior teeth for clients ages twelve through twenty when the crowns meet prior authorization criteria in WAC 388-535-1220 and the provider follows the prior authorization requirements in (d) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) Covers full coverage metal crowns once every five years, per tooth, for permanent posterior teeth to include high noble, titanium, titanium alloys, noble, and predominantly base metal crowns for clients ages eighteen through twenty when they meet prior authorization criteria and the provider follows the prior authorization requirements in (d) and (e) of this subsection.

(c) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The department covers a one surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating, including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(d) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(e) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(9) **Other restorative services.** The department covers:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years without prior authorization if the tooth requires a four or more surface restoration.

(c) Prefabricated stainless steel crowns for primary posterior teeth once every three years without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns for permanent posterior teeth once every three years when prior authorized.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities according to WAC 388-535-1099.

(f) Core buildup, including pins, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1084, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1086 Covered dental-related services for clients through age twenty—Endodontic services. The department covers medically necessary dental-related endodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Pulp capping.** The department considers pulp capping to be included in the payment for the restoration.

(2) **Pulpotomy.** The department covers:

(a) Therapeutic pulpotomy on primary posterior teeth only; and

(b) Pulpal debridement on permanent teeth only, excluding teeth one, sixteen, seventeen, and thirty-two. The department does not pay for pulpal debridement when performed with palliative treatment of dental pain or when performed on the same day as endodontic treatment.

(3) **Endodontic treatment.** The department:

(a) Covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

(b) Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

(c) Considers the following included in endodontic treatment:

(i) Pulpotomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

(iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(d) Pays separately for the following services that are related to the endodontic treatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(e) Requires prior authorization for endodontic retreatment and considers endodontic retreatment to include:

(i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;

(ii) Placement of new filling material; and

(iii) Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

(f) Pays separately for the following services that are related to the endodontic retreatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(g) Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the department.

(h) Covers apexification for apical closures for anterior permanent teeth only on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three interim treatment visits.

(i) Covers apicoectomy and a retrograde fill for anterior teeth only.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1086, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1088 Covered dental-related services for clients through age twenty—Periodontic services. The department covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Surgical periodontal services.** The department covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized; and

(b) Gingivectomy/gingivoplasty for clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Nonsurgical periodontal services.** The department:

(a) Covers periodontal scaling and root planing once per quadrant, per client in a two-year period on a case-by-case basis, when prior authorized for clients ages thirteen through eighteen, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ages nineteen through twenty. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(d) Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(e) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Other periodontal services.** The department:

(a) Covers periodontal maintenance once per client in a twelve-month period on a case-by-case basis, when prior authorized, for clients ages thirteen through eighteen, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least twelve months from the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a twelve month period for clients ages nineteen through twenty. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC 388-535-1099.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1088, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1090 Covered dental-related services for clients through age twenty—Prosthodontics (removable). The department covers medically necessary prosthodontics (removable) services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Prosthodontics.** The department:

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures, except as stated in (c)(ii)(B) of this subsection. Prior authorization requests must meet the criteria in WAC 388-535-1220. In addition, the department requires the dental provider to submit:

(i) Appropriate and diagnostic radiographs of all remaining teeth.

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

(C) Dental and periodontal services completed on all remaining teeth.

(ii) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or a cast metal partial denture.

(b) Covers complete dentures, as follows:

(i) A complete denture, including an immediate denture or overdenture, is covered when prior authorized.

(ii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the complete denture, is considered part of the complete denture procedure and is not paid separately.

(iii) Replacement of an immediate denture with a complete denture is covered if the complete denture is prior authorized at least six months after the seat date of the immediate denture.

(iv) Replacement of a complete denture or overdenture is covered only if prior authorized at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(c) Covers partial dentures, as follows:

(i) A partial denture, including a resin or flexible base partial denture, is covered for anterior and posterior teeth when the partial denture meets the following department coverage criteria.

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing or four or more posterior teeth are missing;

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of the remaining teeth.

(ii) Prior authorization of partial dentures:

(A) Is required for clients ages nine and younger; and

(B) Not required for clients ages ten through twenty.

Documentation supporting the medical necessity for the service must be included in the client's file.

(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial denture, is considered part of the partial denture procedure and is not paid separately.

(iv) Replacement of a resin or flexible base denture is covered only if prior authorized at least three years after the seat date of the resin or flexible base partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria in (c)(i) of this subsection.

(d) Covers cast-metal framework partial dentures, as follows:

(i) Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, are covered for clients ages eighteen through twenty only once in a five-year period, on a case-by-case basis, when prior authorized and department coverage criteria listed in subsection (d)(v) of this subsection are met.

(ii) Cast-metal framework partial dentures for clients ages seventeen and younger are not covered.

(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the cast metal partial denture is considered part of the partial denture procedure and is not paid separately.

(iv) Replacement of a cast metal framework partial denture is covered on a case-by-case basis and only if placed at least five years after the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria listed in (d)(v) of this subsection.

(v) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:

(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;

(D) There are fewer than eight posterior teeth in occlusion;

(E) There is a minimum of four stable teeth remaining per arch; and

(F) There is a five-year prognosis for the retention of the remaining teeth.

(vi) The department may consider resin partial dentures as an alternative if the department determines the criteria for cast metal framework partial dentures listed in (d)(v) of this subsection are not met.

(e) Requires a provider to bill for removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to subsection (2)(e) and (f) for what the department may pay if the removable prosthesis is not delivered and inserted.

(f) Requires a provider to submit the following with a prior authorization request for removable prosthetics for a client residing in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the denture/partial appliance request for skilled nursing facility client form (DSHS 13-788) available from the department's published billing instructions.

(g) Limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (f) of this subsection. The department may consider cast metal partial dentures if the criteria in subsection (1)(d) are met.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the department. The department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthodontics.** The department covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs to complete and partial dentures, once in a twelve month period. The department covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory relines or rebase to a complete or cast-metal partial denture, once in a three-year period when performed at least six months after the seating date. An additional relines or rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

(d) Up to two tissue conditionings, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

(i) The department does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The department may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the prosthesis;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the complete, immediate, or partial dentures; or

(E) Dies.

(f) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1090, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1092 Covered dental-related services for clients through age twenty—Maxillofacial prosthetic services. The department covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) Maxillofacial prosthetics are covered only on a case-by-case basis and when prior authorized; and

(2) The department must preapprove a provider qualified to furnish maxillofacial prosthetics.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1092, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1094 Covered dental-related services for clients through age twenty—Oral and maxillofacial surgery services. The department covers medically necessary oral and maxillofacial surgery services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Oral and maxillofacial surgery services.** The department:

(a) Requires enrolled providers who do not meet the conditions in WAC 388-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 388-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the department's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

- (i) Clients ages eight and younger;
- (ii) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and
- (iii) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(d) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the department. The documentation must include:

- (i) Appropriate consent form signed by the client or the client's legal representative;
 - (ii) Appropriate radiographs;
 - (iii) Medical justification with diagnosis;
 - (iv) Client's blood pressure, when appropriate;
 - (v) A surgical narrative;
 - (vi) A copy of the post-operative instructions; and
 - (vii) A copy of all pre- and post-operative prescriptions.
- (e) Covers routine and surgical extractions.

(f) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The department includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(g) Covers biopsy, as follows:

- (i) Biopsy of soft oral tissue or brush biopsy do not require prior authorization; and
- (ii) All biopsy reports or findings must be kept in the client's dental record.

(h) Covers alveoloplasty only on a case-by-case basis and when prior authorized. The department covers alveoloplasty only when not performed in conjunction with extractions.

(i) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

(j) Covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:

- (i) Removal of lateral exostosis;
- (ii) Removal of torus palatinus or torus mandibularis; and
- (iii) Surgical reduction of soft tissue or osseous tuberosity.

(2) **Surgical incisions.** The department covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The department does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record.

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients through age six. The department covers frenuloplasty/frenulectomy for clients ages seven through twelve only on a case-by-case and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(3) **Occlusal orthotic devices.** (Refer to WAC 388-535-1098 (5)(c) for occlusal guard coverage and limitations on coverage.) The department covers:

(a) Occlusal orthotic devices for clients ages twelve through twenty only on a case-by-case basis and when prior authorized.

(b) An occlusal orthotic device only as a laboratory processed full arch appliance.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1094, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1096 Covered dental-related services for clients through age twenty—Orthodontic services. The department covers orthodontic services, subject to the coverage limitations listed, for clients through age twenty according to chapter 388-535A WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1096, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1098 Covered dental-related services for clients through age twenty—Adjunctive general services. The department covers medically necessary dental-related adjunctive general services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Adjunctive general services.** The department:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 388-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:

(i) The provider's current anesthesia permit must be on file with the department.

(ii) For clients of the division of developmental disabilities, the services must be performed according to WAC 388-535-1099.

(iii) For clients ages eight and younger, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(iv) For clients ages nine through twenty, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. Oral surgery services listed in WAC 388-535-1094 do not require prior authorization.

(v) Prior authorization is not required for oral or parenteral conscious sedation for any dental service. Documentation supporting the medical necessity of the service must be in the client's record.

(vi) For clients ages nine through eighteen who have a diagnosis of oral facial cleft, the department does not require prior authorization for deep sedation or general anesthesia

services when the dental procedure is directly related to the oral facial cleft treatment.

(vii) For clients through age twenty, the provider must bill anesthesia services using the CDT codes listed in the department's current published billing instructions.

(d) Covers inhalation of nitrous oxide for clients through age twenty, once per day.

(e) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(f) Pays for anesthesia services according to WAC 388-535-1350.

(g) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the department for the services to be covered.

(2) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or ambulatory surgical center only for:

(a) Clients ages eight and younger.

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized.

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Professional visits.** The department covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The department limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client.

(c) Emergency office visits after regularly scheduled hours. The department limits payment to one emergency visit per day, per provider.

(4) **Drugs and/or medicaments (pharmaceuticals).**

The department covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia. The department's dental program does not pay for oral sedation medications.

(5) **Miscellaneous services.** The department covers:

(a) Behavior management when the assistance of one additional dental staff other than the dentist is required, for:

(i) Clients ages eight and younger;

(ii) Clients ages nine through twenty, only on a case-by-case basis and when prior authorized;

(iii) Clients of the division of developmental disabilities according to WAC 388-535-1099; and

(iv) Clients who reside in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 388-535-1094(3) for occlusal

orthotic device coverage and coverage limitations.) The department covers:

(i) An occlusal guard only for clients ages twelve through twenty when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1098, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1099 Covered dental-related services for clients of the division of developmental disabilities.

The department pays for dental-related services under the categories of services listed in this section for clients of the division of developmental disabilities, subject to the coverage limitations listed. Chapter 388-535 WAC applies to clients of the division of developmental disabilities unless otherwise stated in this section.

(1) **Preventive services.**

(a) **Dental prophylaxis.** The department covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(b) **Topical fluoride treatment.** The department covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

(c) **Sealants.** The department covers sealants:

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Crowns.** The department covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and molars, as follows:

(a) For clients ages twenty and younger, the department does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.

(b) For clients ages twenty-one and older, the department requires prior authorization for stainless steel crowns.

(3) **Periodontic services.**

(a) **Surgical periodontal services.** The department covers:

(i) Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).

(ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Nonsurgical periodontal services.** The department covers:

(i) Periodontal scaling and root planing, up to two times per quadrant in a twelve-month period.

(ii) Periodontal scaling (four quadrants) substitutes for an eligible periodontal maintenance or oral prophylaxis, twice in a twelve-month period.

(4) **Adjunctive general services.**

(a) **Adjunctive general services.** The department covers:

(i) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

(ii) Sedations services according to WAC 388-535-1098 (1)(c) and (e).

(b) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 388-535-1082, 388-535-1084, 388-535-1086, 388-535-1088, and 388-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(5) **Miscellaneous services—Behavior management.** The department covers behavior management provided in dental offices or dental clinics for clients of any age. Documentation supporting the medical necessity of the service must be included in the client's record.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1099, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1100 Dental-related services not covered for clients through age twenty. (1) The department does not cover the following for clients through age twenty:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC 388-534-0100 for information about the EPSDT program.

(b) Any service specifically excluded by statute.

(c) More costly services when less costly, equally effective services as determined by the department are available.

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) Which the department or the centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The department's current published documents.

(2) The department does not cover dental-related services listed under the following categories of service for clients through age twenty (see subsection (1)(a) of this section for services provided under the EPSDT program):

(a) **Diagnostic services.** The department does not cover:

(i) Extraoral radiographs.

(ii) Comprehensive periodontal evaluations.

(b) **Preventive services.** The department does not cover:

(i) Nutritional counseling for control of dental disease.

(ii) Tobacco counseling for the control and prevention of oral disease.

(iii) Removable space maintainers of any type.

(iv) Sealants placed on a tooth with the same-day occlusal restoration, pre-existing occlusal restoration, or a tooth with occlusal decay.

(v) Space maintainers for clients ages nineteen through twenty.

(c) **Restorative services.** The department does not cover:

(i) Gold foil restorations.

(ii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.

(iii) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).

(iv) Crowns for third molars one, sixteen, seventeen, and thirty-two.

(v) Temporary or provisional crowns (including ion crowns).

(vi) Labial veneer resin or porcelain laminate restorations.

(vii) Any type of coping.

(viii) Crown repairs.

(ix) Polishing or recontouring restorations or overhang removal for any type of restoration.

(d) **Endodontic services.** The department does not cover:

(i) Any endodontic therapy on primary teeth, except as described in WAC 388-535-1086 (3)(a).

(ii) Apexification/recalcification for root resorption of permanent anterior teeth.

(iii) Any apexification/recalcification procedures for bicuspid or molar teeth.

(iv) Any apicoectomy/periradicular services for bicuspid or molar teeth.

(v) Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The department does not cover:

(i) Surgical periodontal services including, but not limited to:

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

(E) Biological material to aid in soft and osseous tissue regeneration.

(F) Guided tissue regeneration.

(G) Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts.

(H) Distal or proximal wedge procedures.

(ii) Nonsurgical periodontal services including, but not limited to:

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement.

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

(f) **Removable prosthodontics.** The department does not cover:

(i) Removable unilateral partial dentures.

(ii) Any interim complete or partial dentures.

- (iii) Precision attachments.
- (iv) Replacement of replaceable parts for semi-precision or precision attachments.
- (g) **Implant services.** The department does not cover:
 - (i) Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eposteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer.
 - (ii) Any maintenance or repairs to procedures listed in (g)(i) of this subsection.
 - (iii) The removal of any implant as described in (g)(i) of this subsection.
- (h) **Fixed prosthodontics.** The department does not cover:
 - (i) Any type of fixed partial denture pontic or fixed partial denture retainer.
 - (ii) Any type of precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.
- (i) **Oral and maxillofacial surgery.** The department does not cover:
 - (i) Any oral surgery service not listed in WAC 388-535-1094.
 - (ii) Any oral surgery service that is not listed in the department's list of covered current procedural terminology (CPT) codes published in the department's current rules or billing instructions.
- (j) **Adjunctive general services.** The department does not cover:
 - (i) Anesthesia, including, but not limited to:
 - (A) Local anesthesia as a separate procedure.
 - (B) Regional block anesthesia as a separate procedure.
 - (C) Trigeminal division block anesthesia as a separate procedure.
 - (D) Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative.
 - (E) Application of any type of desensitizing medicament or resin.
 - (ii) Other general services including, but not limited to:
 - (A) Fabrication of an athletic mouthguard.
 - (B) Occlusion analysis.
 - (C) Occlusal adjustment or odontoplasties.
 - (D) Enamel microabrasion.
 - (E) Dental supplies such as toothbrushes, toothpaste, floss, and other take home items.
 - (F) Dentist's or dental hygienist's time writing or calling in prescriptions.
 - (G) Dentist's or dental hygienist's time consulting with clients on the phone.
 - (H) Educational supplies.
 - (I) Nonmedical equipment or supplies.
 - (J) Personal comfort items or services.
 - (K) Provider mileage or travel costs.
 - (L) Fees for no-show, cancelled, or late arrival appointments.
 - (M) Service charges of any type, including fees to create or copy charts.
 - (N) Office supplies used in conjunction with an office visit.

- (O) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1100, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-078, § 388-535-1100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1100, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1220 Obtaining prior authorization for dental-related services for clients through age twenty.

- (1) The department uses the determination process for payment described in WAC 388-501-0165 for covered dental-related services for clients through age twenty that require prior authorization.

(2) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611.

- (3) The department may request additional information as follows:

- (a) Additional radiographs (X rays) (refer to WAC 388-535-1080(2));
- (b) Study models;
- (c) Photographs; and
- (d) Any other information as determined by the department.

- (4) The department may require second opinions and/or consultations before authorizing any procedure.

(5) When the department authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

- (6) The department denies a request for a dental-related service when the requested service:

- (a) Is covered by another department program;
- (b) Is covered by an agency or other entity outside the department; or
- (c) Fails to meet the program criteria, limitations, or restrictions in chapter 388-535 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-042, § 388-535-1220, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-078, § 388-535-1220, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1220, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase

access to dental services for Medicaid-eligible clients ages five and younger.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be age five and younger. Once enrolled in the ABCD program, eligible clients are covered until their sixth birthday.

(b) Clients eligible under one of the following medical assistance programs are eligible for the ABCD program:

- (i) Categorically needy program (CNP);
- (ii) Limited casualty program-medically needy program (LCP-MNP);
- (iii) Children's health program; or
- (iv) State children's health insurance program (SCHIP).

(c) ABCD program services for eligible clients enrolled in a managed care organization (MCO) plan are paid through the fee-for-service payment system.

(2) Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

- (a) Oral health education;
- (b) "Anticipatory guidance" (expectations of the client and the client's family members, including the importance of keeping appointments); and
- (c) Assistance with transportation, interpreter services, and other issues related to dental services.

(3) Dentists must be certified through the continuing education program in the University of Washington School of Pediatric Dentistry to furnish ABCD program services.

(4) The department pays enhanced fees to ABCD-certified participating providers for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

- (i) Must have a duration of at least twenty minutes for each visit;
- (ii) Is limited to one visit per day per family, up to two visits per calendar year; and
- (iii) Must include all of the following:

- (A) "Lift lip" training;
- (B) Oral hygiene training;
- (C) Risk assessment for early childhood caries;
- (D) Dietary counseling;
- (E) Topical application of gel or varnish;
- (F) Discussion of fluoride supplements; and

(G) Documentation in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

(b) Comprehensive and periodic oral evaluation, up to two visits per client, per calendar year;

(c) Amalgam and resin restorations on primary teeth, as specified in current department-published documents;

(d) Therapeutic pulpotomy;

(e) Prefabricated stainless steel crowns on primary teeth, as specified in current department-published documents;

(f) Resin-based composite crowns on anterior primary teeth; and

(g) Other dental-related services, as specified in current department-published documents.

(5) The client's file must show documentation of the ABCD program services provided.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-042, § 388-535-1245, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. 02-11-136, § 388-535-1245, filed 5/21/02, effective 6/21/02.]

WAC 388-535-1247 Dental-related services for clients age twenty-one and older—General. (1) Subject to coverage limitations, the department pays for dental-related services and procedures provided to clients age twenty-one and older when the services and procedures:

- (a) Are within the scope of an eligible client's medical care program;
- (b) Are medically necessary as defined in WAC 388-500-0005;
- (c) Meet the department's prior authorization requirements, if any;
- (d) Are documented in the client's record in accordance with chapter 388-502 WAC;
- (e) Are within prevailing standard of care accepted dental or medical practice standards;
- (f) Are consistent with a diagnosis of dental disease or condition;
- (g) Are reasonable in amount and duration of care, treatment, or service; and
- (h) Are listed as covered in the department's published rules, billing instructions and fee schedules.

(2) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services under the provisions of WAC 388-535-1099.

(3) The department evaluates a request for dental-related services:

- (a) That are in excess of the dental program's limitations or restrictions, according to WAC 388-501-0169; and
- (b) That are listed as noncovered under the provisions in WAC 388-501-0160.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1247, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1255 Covered dental-related services—Adults. The department covers dental-related diagnostic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Clinical oral evaluations.** The department covers:

(a) Oral health evaluations and assessments. The services must be documented in the client's record in accordance with WAC 388-502-0020;

(b) Periodic oral evaluations as defined in WAC 388-535-1050, once every twelve months. Twelve months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation;

(c) Limited oral evaluations as defined in WAC 388-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

- (i) Must be to evaluate the client for a:
 - (A) Specific dental problem or oral health complaint;
 - (B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a dentist, is limited to the initial examination appointment. The department does not cover an additional limited oral examination by a dentist for the same client until three months after the removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC 388-535-1050, once per client, per provider or clinic, as an initial examination. The department covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years;

(e) Limited visual oral assessments as defined in WAC 388-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical evaluation services;

(ii) Performed to determine the need for fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(2) **Radiographs (X rays).** The department:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The department requires original radiographs to be retained by the provider as part of the client's dental record, and duplicate radiographs to be submitted with prior authorization requests or when copies of dental records are required.

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers intraoral complete series (includes four bitewings), once in a three-year period only if the department has not paid for a panoramic radiograph for the same client in the same three-year period.

(d) Covers periapical radiographs that are not included in a complete series. Documentation supporting the medical necessity for these must be in the client's record.

(e) Covers up to four bitewing radiographs once in a twelve month period.

(f) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the department has not paid for an intraoral complete series for the same client in the same three-year period.

(g) May cover panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1255, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-079, § 388-535-1255, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1257 Covered dental-related services for clients age twenty-one and older—Preventive services. The department covers dental-related preventive services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Dental prophylaxis.** The department covers dental prophylaxis:

(a) Which includes scaling and polishing procedures to remove coronal plaque, calculus, and stains once every twelve months;

(b) Only when the service is performed twelve months after periodontal scaling and root planing, or periodontal maintenance services;

(c) Only when not performed on the same date of service as periodontal scaling and root planing, or periodontal maintenance, gingivectomy or gingivoplasty; and

(d) For clients of the division of development disabilities according to WAC 388-535-1099.

(2) **Topical fluoride treatment.** The department covers:

(a) Fluoride rinse, foam or gel, once within a twelve-month period;

(b) Fluoride varnish, rinse, foam or gel for clients who are age sixty-five and older, or clients who reside in alternative living facilities, up to three times within a twelve-month period;

(c) Additional topical fluoride applications when prior authorized; and

(d) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 388-535-1099.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1257, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1259 Covered dental-related services for clients age twenty-one and older—Restorative services. The department covers dental-related restorative services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Amalgam restorations for permanent teeth.** The department:

(a) Considers tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration;

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration;

(c) Considers buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth;

(d) Considers multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration;

(e) Covers two occlusal amalgam restorations for teeth one, two, three, fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure;

(f) Covers amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period;

(g) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen and sixteen, once per client, per provider or clinic, in a two-year period. See also (e) of this subsection; and

(h) Does not pay for replacement of an amalgam restoration by the same provider on a permanent posterior tooth within a two-year period unless the restoration has an additional adjoining carious surface. The department pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(2) **Resin-based composite restorations for permanent teeth.** The department:

(a) Considers tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration;

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration;

(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth;

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the DEJ to be sealants. The department does not cover sealants for clients age twenty-one and older;

(e) Considers multiple preventive restorative resins or flowable composite resins for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration;

(f) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial and/or distal) of posterior teeth or the incisal surface of anterior teeth;

(g) Covers two occlusal resin-based composite restorations for teeth one, two, three, fourteen, fifteen, and sixteen if the restorations are anatomically separated by sound tooth structure;

(h) Covers resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period;

(i) Covers resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen and sixteen, once per client, per provider or clinic, in a two-year period. See also (g) of this subsection;

(j) Covers resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period; and

(k) Does not pay for replacement of resin-based composite restorations by the same provider on permanent teeth within a two-year period unless the restoration has an additional adjoining carious surface. The department pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(3) **Crowns.** The department:

(a) Does not cover permanent crowns for clients age twenty-one and older, except for prefabricated stainless steel

crowns for posterior permanent teeth on a case-by-case basis when prior authorized; and

(b) Covers crowns for clients of the division of developmental disabilities according to WAC 388-535-1099.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1259, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1261 Covered dental-related services for clients age twenty-one and older—Endodontic services. The department covers dental-related endodontic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Pulpal debridement.** The department covers pulpal debridement on permanent teeth. Pulpal debridement is not covered when performed with palliative treatment or when performed on the same day as endodontic treatment.

(2) **Endodontic treatment.** The department:

(a) Covers endodontic treatment for permanent anterior teeth only;

(b) Considers the following included in endodontic treatment:

(i) Pulpectomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

(iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(c) Pays separately for the following services that are related to the endodontic treatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(d) Requires prior authorization for endodontic retreatment and considers endodontic retreatment to include:

(i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;

(ii) Placement of new filling material; and

(iii) Retreatment for permanent maxillary and mandibular anterior teeth only.

(e) Pays separately for the following services that are related to the endodontic retreatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(f) Does not pay for endodontic retreatment when provided by the original treating provider or clinic.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1261, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1263 Covered dental-related services for clients age twenty-one and older—Periodontic services. The department covers dental-related periodontic services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Surgical periodontal services.** The department covers surgical periodontal services, including all postoperative

care for clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Nonsurgical periodontal services.** The department:

(a) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitute for periodontal scaling and root planing.

(c) Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(d) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Other periodontal services.** The department:

(a) Covers periodontal maintenance once per client in a twelve-month period when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets existing published periodontal guidelines; and

(iv) Performed at least twelve months from the date of completion of periodontal scaling and root planing or surgical periodontal treatment.

(b) Covers periodontal maintenance only if performed on a different date of service as prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(c) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC 388-535-1099.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1263, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1266 Covered dental-related services for clients age twenty-one and older—Prosthodontics (removable). The department covers dental-related prosthodontics (removable) services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Removable prosthodontics.** The department:

(a) Requires prior authorization requests for all removable prosthodontics and prosthodontic-related procedures listed in this subsection. Prior authorization requests must meet the criteria in WAC 535-1280. In addition, the department requires the dental provider to:

(i) Submit:

(A) Appropriate and diagnostic radiographs of all remaining teeth.

(B) A dental record that identifies:

(I) All missing teeth for both arches;

(II) Teeth that are to be extracted; and

(III) Dental and periodontal services completed on all remaining teeth.

(C) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or cast metal partial denture.

(ii) Obtain a signed agreement of acceptance from the client at the conclusion of the final denture try-in for a department authorized complete denture or a cast-metal denture described in this section. If the client abandons the complete denture or the cast-metal partial denture after signing the agreement of acceptance, the department will deny subsequent requests for the same type dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement that documents the client's acceptance of the dental prosthesis must be submitted to the department's dental prior authorization section before the department pays the claim.

(b) Covers a complete denture, as follows:

(i) A complete denture, including an immediate denture or overdenture, is covered when prior authorized and the complete denture meets department coverage criteria;

(ii) Post-delivery care (e.g., adjustments, soft relines, and repairs) provided within three months of the seat date of a complete denture, is considered part of the complete denture procedure and is not paid separately;

(iii) Replacement of an immediate denture with a complete denture is covered only when the replacement occurs at least six months from the seat date of the immediate denture. The replacement complete denture must be prior authorized; and

(iv) Replacement of a complete denture or overdenture is covered only when the replacement occurs at least five years from the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(c) Covers partial dentures as follows:

(i) Department authorization and payment for a resin or flexible base partial denture for anterior and posterior teeth is based on the following criteria:

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing, or four or more posterior teeth per arch are missing;

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of all remaining teeth.

(ii) Post-delivery care (e.g. adjustments, soft relines, and repairs) provided after three months from the seat date of the partial denture, is considered part of the partial denture and is not paid separately; and

(iii) Replacement of a resin or flexible base denture is covered only when the replacement occurs at least three years from the seat date of the partial denture being replaced. The

replacement denture must be prior authorized and meet department coverage criteria.

(d) Covers cast metal framework partial dentures as follows:

(i) A cast metal framework with resin-based denture, including any conventional clasps, rests, and teeth, is covered on a case-by-case basis when prior authorized and department coverage criteria listed in (d)(iv) of this subsection are met.

(ii) Post-delivery care (e.g., adjustments, soft relines, and repairs) provided within three months of the seat date of the cast metal partial denture, is considered part of the partial denture procedure and is not paid separately.

(iii) Replacement of a cast metal framework partial denture is covered on a case-by-case basis and only when the replacement occurs at least five years from the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria listed in (d)(iv) of this subsection.

(iv) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:

(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;

(D) There are fewer than eight posterior teeth in occlusion;

(E) There is a minimum of four stable teeth remaining per arch;

(F) There is a five-year prognosis, based on the sole discretion of the department, for retention of all remaining teeth.

(v) The department may consider resin partial dentures as an alternative if the criteria for cast metal framework partial dentures listed in (d)(iv) of this subsection do not meet department specifications.

(e) Requires the provider to bill for covered removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to (2)(c) and (d) of this subsection if the removable prostheses is not delivered and inserted.

(f) Requires a provider to submit the following with prior authorization requests for removable prosthetics for a client residing in a nursing home, group home, or other facility:

(i) The client's medical diagnosis and prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client form (DSHS 13-788) available from the department.

(g) Limits removable partial dentures to resin based partial dentures for all clients who reside in one of the facilities listed in (f) of this subsection. The department may consider cast metal partial dentures if the criteria in (d) of this subsection are met.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the department. The department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthetics.** The department covers:

(a) Repairs to complete and partial dentures;

(b) A laboratory reline or rebase to a complete or cast metal partial denture, once in a three-year period when performed at least six months after the seat date; and

(c) Laboratory fees, subject to all of the following:

(i) The department does not pay laboratory and professional fees for complete and partial dentures, except as stated in (ii) of this subsection;

(ii) The department may pay part of billed laboratory fees when the provider has obtained prior authorization from the department, and:

(A) At the time of delivery of the prosthesis, the patient is no longer an eligible medical assistance client (see also WAC 388-535-1280(3));

(B) The client moves from the state; or

(C) The client dies.

(ii) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 07-06-041, § 388-535-1266, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1267 Covered dental-related services for clients age twenty-one and older—Oral and maxillofacial surgery services. The department covers oral and maxillofacial surgery services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

(1) **Oral and maxillofacial surgery services.** The department:

(a) Requires enrolled dental providers who do not meet the conditions in WAC 388-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC 388-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the department's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Does not cover oral surgery services described in WAC 388-535-1267 that are performed in a hospital operating room or ambulatory surgery center.

(d) Requires the client's record to include supporting documentation for each type of extraction or any other surgical procedure billed to the department. The documentation must include:

(i) An appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

(iv) Client's blood pressure, when appropriate;

(v) A surgical narrative;

- (vi) A copy of the post-operative instructions; and
- (vii) A copy of all pre- and post-operative prescriptions.
- (e) Covers routine and surgical extractions.
- (f) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The department includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.
- (g) Covers biopsy, as follows:
 - (i) Biopsy of soft oral tissue or brush biopsy do not require prior authorization; and
 - (ii) All biopsy reports must be kept in the client's record.
- (h) Covers alveoloplasty only when three or more teeth are extracted per arch.
 - (i) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.
 - (j) Covers only the following excisions of bone tissue in conjunction with placement of immediate, complete, or partial dentures when prior authorized:
 - (i) Removal of lateral exostosis;
 - (ii) Removal of torus palatinus or torus mandibularis; and
 - (iii) Surgical reduction of soft tissue or osseous tuberosity.

(2) **Surgical incision-related services.** The department covers the following surgical incision-related services:

- (a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The department does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record; and
- (b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue when prior authorized. Documentation supporting medical necessity must be in the client's record.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1267, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1269 Covered dental-related services for clients age twenty-one and older—Adjunctive general services. The department covers dental-related adjunctive general services only as listed in this section for clients age twenty-one and older (for dental-related services provided to clients eligible under the GA-U or ADATSA program, see WAC 388-535-1065).

- (1) **Adjunctive general services.** The department:
 - (a) Covers palliative (emergency) treatment, not to include pulpal debridement, for treatment of dental pain, limited to once per day, per client, as follows:
 - (i) The treatment must occur during limited evaluation appointments;
 - (ii) A comprehensive description of diagnosis and services provided must be documented in the client's record; and
 - (iii) Appropriate radiographs must be in the client's record to support medical necessity for the treatment.
 - (b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.
 - (c) Covers office based oral or parenteral sedation:
 - (i) For services listed as covered in WAC 388-535-1267;
 - (ii) For all current published current procedural terminology (CPT) dental codes;

- (ii) When the provider's current valid anesthesia permit is on file with the department; and
- (iv) For clients of the division of developmental disabilities according to WAC 388-535-1099.
- (d) Covers office based general anesthesia for:
 - (i) Extraction of three or more teeth;
 - (ii) Services listed as covered in WAC 388-535-1267
- (1)(h) and (j);
 - (iii) For all current published CPT dental codes;
 - (iv) When the provider's current valid anesthesia permit is on file with the department; and
 - (v) For clients of the division of developmental disabilities, according to WAC 388-535-1099.
- (e) Covers inhalation of nitrous oxide, once per day.
- (f) Requires providers of oral or parenteral conscious sedation, or general anesthesia to meet:
 - (i) The prevailing standard of care;
 - (ii) The provider's professional organizational guidelines;
 - (iii) The requirements in chapter 246-817 WAC; and
 - (iv) Relevant department of health (DOH) medical, dental, and nursing anesthesia regulations;
- (g) Pays for anesthesia services according to WAC 388-535-1350;
- (h) Covers professional consultation/diagnostic services as follows:
 - (i) A dentist or a physician other than the practitioner providing treatment must provide the services; and
 - (ii) A client must be referred by the department for the services to be covered.

(2) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or ambulatory surgical center for clients of the division of developmental disabilities according to WAC 388-535-1099.

(3) **Professional visits.** The department covers:

- (a) Up to two house/extended care facility calls (visits) per facility, per provider. The department limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client. The department does not pay for additional hospital calls if billed for the same client on the same day.

(c) Emergency office visits after regularly scheduled hours. The department limits payment to one emergency visit per day, per provider.

(4) **Drugs and/or medicaments (pharmaceuticals).** The department covers drugs and/or medicaments (pharmaceuticals) only when used with parenteral conscious sedation, deep sedation, or general anesthesia. The department's dental program does not pay for oral sedation medications.

(5) **Miscellaneous services.** The department covers:

- (a) Behavior management that requires the assistance of one additional dental staff other than the dentist only for clients of the division of developmental disabilities. See WAC 388-535-1099.

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity for the service must be in the client's record.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1269, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1271 Dental-related services not covered for clients age twenty-one and older. (1) The department does not cover the following for clients age twenty-one and older (see WAC 388-535-1065 for dental-related services for clients eligible under the GA-U or ADATSA program):

(a) The dental-related services and procedures described in subsection (2) of this section;

(b) Any service specifically excluded by statute;

(c) More costly services when less costly, equally effective services as determined by the department are available; and

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) Which the department or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The department's published documents (e.g., billing instructions).

(2) The department does not cover dental-related services listed under the following categories of service for clients age twenty-one and older:

(a) **Diagnostic services.** The department does not cover:

(i) Detailed and extensive oral evaluations or re-evaluations;

(ii) Comprehensive periodontal evaluations;

(iii) Extraoral or occlusal intraoral radiographs;

(iv) Posterior-anterior or lateral skull and facial bone survey films;

(v) Sialography;

(vi) Any temporomandibular joint films;

(vii) Tomographic survey;

(viii) Cephalometric films;

(ix) Oral/facial photographic images;

(x) Viral cultures, genetic testing, caries susceptibility tests, adjunctive prediagnostic tests, or pulp vitality tests; or

(xi) Diagnostic casts.

(b) **Preventive services.** The department does not cover:

(i) Nutritional counseling for control of dental disease;

(ii) Tobacco counseling for the control and prevention of oral disease;

(iii) Oral hygiene instructions (included as part of the global fee for oral prophylaxis);

(iv) Removable space maintainers of any type;

(v) Sealants;

(vi) Space maintainers of any type or recementation of space maintainers; or

(vii) Fluoride trays of any type.

(c) **Restorative services.** The department does not cover:

(i) Restorative/operative procedures performed in a hospital operating room or ambulatory surgical center for clients age twenty-one and older. For clients of the division of developmental disabilities, see WAC 388-535-1099;

(ii) Gold foil restorations;

(iii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations;

(iv) Prefabricated resin crowns;

(v) Temporary or provisional crowns (including ion crowns);

(vi) Any type of permanent or temporary crown. For clients of the division of developmental disabilities see WAC 388-535-1099;

(vii) Recementation of any crown, inlay/onlay, or any other type of indirect restoration;

(viii) Sedative fillings;

(ix) Preventive restorative resins;

(x) Any type of core buildup, cast post and core, or prefabricated post and core;

(xi) Labial veneer resin or porcelain laminate restoration;

(xii) Any type of coping;

(xiii) Crown repairs; or

(xix) Polishing or recontouring restorations or overhang removal for any type of restoration.

(d) **Endodontic services.** The department does not cover:

(i) Indirect or direct pulp caps;

(ii) Endodontic therapy on any primary teeth for clients age twenty-one and older;

(iii) Endodontic therapy on permanent bicuspids or molar teeth;

(iv) Any apexification/recalcification procedures;

(v) Any apicoectomy/periradicular service; or

(vi) Any surgical endodontic procedures including, but not limited to, retrograde fillings, root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The department does not cover:

(i) Surgical periodontal services that include, but are not limited to:

(A) Gingival or apical flap procedures;

(B) Clinical crown lengthening;

(C) Any type of osseous surgery;

(D) Bone or soft tissue grafts;

(E) Biological material to aid in soft and osseous tissue regeneration;

(F) Guided tissue regeneration;

(G) Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts; or

(H) Distal or proximal wedge procedures; or

(ii) Nonsurgical periodontal services, including but not limited to:

(A) Intracoronal or extracoronal provisional splinting;

(B) Full mouth debridement;

(C) Localized delivery of chemotherapeutic agents; or

(D) Any other type of nonsurgical periodontal service.

(f) **Prosthodontics (removable).** The department does not cover any type of:

(i) Removable unilateral partial dentures;

(ii) Adjustments to any removable prosthesis;

(iii) Chairside complete or partial denture relines;

(iv) Any interim complete or partial denture;

(v) Precision attachments; or

(vi) Replacement of replaceable parts for semi-precision or precision attachments.

(g) **Oral and maxillofacial prosthetic services.** The department does not cover any type of oral or facial prosthesis other than those listed in WAC 388-535-1266.

(h) **Implant services.** The department does not cover:

(i) Any implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eosteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer;

(ii) Any maintenance or repairs to procedures listed in (h)(i) of this subsection; or

(iii) The removal of any implant as described in (h)(i) of this subsection.

(i) **Prosthodontics (fixed).** The department does not cover any type of:

(i) Fixed partial denture pontic;

(ii) Fixed partial denture retainer;

(iii) Precision attachment, stress breaker, connector bar, coping, or cast post; or

(iv) Other fixed attachment or prosthesis.

(j) **Oral and maxillofacial surgery.** The department does not cover:

(i) Any nonemergency oral surgery performed in a hospital or ambulatory surgical center for current dental terminology (CDT) procedures;

(ii) Vestibuloplasty;

(iii) Frenuloplasty/frenulectomy;

(iv) Any oral surgery service not listed in WAC 388-535-1267;

(v) Any oral surgery service that is not listed in the department's list of covered current procedural terminology (CPT) codes published in the department's current rules or billing instructions;

(vi) Any type of occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device; or

(vii) Any type of orthodontic service or appliance.

(k) **Adjunctive general services.** The department does not cover:

(i) Anesthesia to include:

(A) Local anesthesia as a separate procedure;

(B) Regional block anesthesia as a separate procedure;

(C) Trigeminal division block anesthesia as a separate procedure;

(D) Analgesia or anxiolysis as a separate procedure except for inhalation of nitrous oxide;

(E) Medication for oral sedation, or therapeutic drug injections, including antibiotic or injection of sedative; or

(F) Application of any type of desensitizing medicament or resin.

(ii) Other general services including, but not limited to:

(A) Fabrication of athletic mouthguard, occlusal guard, or nightguard;

(B) Occlusion analysis;

(C) Occlusal adjustment or odontoplasties;

(D) Enamel microabrasion;

(E) Dental supplies, including but not limited to, toothbrushes, toothpaste, floss, and other take home items;

(F) Dentist's or dental hygienist's time writing or calling in prescriptions;

(G) Dentist's or dental hygienist's time consulting with clients on the phone;

(H) Educational supplies;

(I) Nonmedical equipment or supplies;

(J) Personal comfort items or services;

(K) Provider mileage or travel costs;

(L) Missed or late appointment fees;

(M) Service charges of any type, including fees to create or copy charts;

(N) Office supplies used in conjunction with an office visit; or

(O) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1271, filed 3/1/07, effective 4/1/07.]

WAC 388-535-1280 Obtaining prior authorization for dental-related services for clients age twenty-one and older. (1) The department uses the determination process described in WAC 388-501-0165 for covered dental-related services for clients age twenty-one and older that require prior authorization.

(2) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611.

(3) The department may request additional information as follows:

(a) Additional radiographs (X rays) (refer to WAC 388-535-1255(2));

(b) Study models;

(c) Photographs; and

(d) Any other information as determined by the department.

(4) The department may require second opinions and/or consultations before authorizing any procedure.

(5) When the department authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary, it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

(6) The department denies a request for a dental-related service when the requested service:

(a) Is covered by another department program;

(b) Is covered by an agency or other entity outside the department; or

(c) Fails to meet the program criteria, limitations, or restrictions in chapter 388-535 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 07-06-041, § 388-535-1280, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-080, § 388-535-1280, filed 9/12/03, effective 10/13/03.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

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| 388-543-1100 | Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services. |
| 388-543-1150 | Limits and limitation extensions. |
| 388-543-1300 | Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. |
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WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services. The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics, orthotics, and medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (**EPSDT**) program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(1) The department covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when they are:

(a) Within the scope of an eligible client's medical care program (see WAC 388-501-0060 and 388-501-0065);

(b) Within accepted medical or physical medicine community standards of practice;

(c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC). Except for dual eligible Medicare/Medicaid clients when Medicare is the primary payer and the department is being billed for co-pay and/or deductible only:

(i) The prescriber must use DSHS 13-794 (Health and Recovery Services (HRSA) Prescription Form) to write the prescription. The form is available for download at <http://www1.dshs.wa.gov/msa/forms/eforms.html>; and;

(ii) The prescription (DSHS 13-794) must:

(A) Be signed and dated by the prescriber;

(B) Be no older than one year from the date the prescriber signs the prescription; and

(C) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity;

(e) Billed to the department as the payor of last resort only. The department does not pay first and then collect from Medicare and;

(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

(i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the

client's condition written by the prescribing physician, ARNP, PAC, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; and/or

(ii) Video and/or photograph(s) of the client demonstrating the impairments as well as client's ability to use the requested equipment, when applicable.

(2) The department evaluates a request for any equipment or device listed as noncovered in WAC 388-543-1300 under the provisions of WAC 388-501-0160.

(3) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165.

(4) The department evaluates requests for covered services in this chapter that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.

(5) The department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both **Medicare** and Medicaid, and is staying in a **nursing facility** in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(6) The department covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in the department's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.

(7) An interested party may request the department to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (including FDA approval, if required); and

(d) Any additional information the requester feels is important.

(8) The department bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

(9) The department covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.

(10) The department covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician, ARNP, or PAC, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;

(b) Wheelchairs and other DME;

(c) Prosthetic/orthotic devices;

(d) Surgical/ostomy appliances and urological supplies;

- (e) Bandages, dressings, and tapes;
- (f) Equipment and supplies for the management of diabetes; and
- (g) Other medical equipment and supplies listed in department published issuances.

(11) The department evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

(12) For a client in a **nursing facility**, the department covers only the following when medically necessary. All other DME and supplies identified in the department's billing instructions are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4).

(a) The department covers:

(i) The purchase and repair of a speech generating device (SGD) and one of the following:

(A) A powered or manual wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate; or

(B) A specialty bed or the rental of a specialty bed outside of the skilled nursing facility per diem when:

(I) The specialty bed is intended to help the client heal; and

(II) The client's nutrition and laboratory values are within normal limits.

(b) A heavy duty bariatric bed is not considered a specialty bed.

(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.

(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1100, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1100, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 34.05.353. 03-12-005, § 388-543-1100, filed 5/22/03, effective 6/22/03. Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1100, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1150 Limits and limitation extensions.

The department covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). The department limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client. In order to exceed the stated limits, the provider must request a limitation extension (LE), which is a form of prior authorization (PA). The department evaluates such requests for LE under the provisions of WAC 388-501-0169. Procedures for LE are found in department billing instructions. The follow-

ing items and quantities do not require prior authorization; requests to exceed the stated quantities require LE:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one pint per month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month;

(e) Disinfectant spray - one twelve-ounce bottle or can per six-month period; or

(f) Periwash (when soap and water are medically contraindicated) - one five-ounce bottle of concentrate solution per six-month period.

(2) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three-month period; and

(b) Spring-powered device for lancet - one in a six-month period.

(3) Braces, belts and supportive devices:

(a) Custom vascular supports (CVS) - two pair per six-month period. CVS fitting fee - two per six-month period;

(b) Surgical stockings (below-the-knee, above-the-knee, thigh-high, or full-length) - two pair per six-month period;

(c) Graduated compression stockings for pregnancy support (pantyhose style) - two per twelve-month period;

(d) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(e) Ankle, elbow, or wrist brace - two per twelve-month period;

(f) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(g) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. The department does not allow the following to be used on a faceplate in combination with drainable pouches (refer to the billing instructions for further details):

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(6) Supplies associated with client-owned transcutaneous electrical nerve stimulators (TENS):

(a) For a four-lead TENS unit - two kits per month. (A kit contains two leads, conductive paste or gel, adhesive, adhesive remover, skin preparation material, batteries, and a battery charger for rechargeable batteries.)

(b) For a two-lead TENS unit - one kit per month.

(c) TENS tape patches (for use with carbon rubber electrodes only) are allowed when they are not used in combination with a kit(s).

(d) A TENS stand alone replacement battery charger is allowed when it is not used in combination with a kit(s).

(7) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a backsheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a topsheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the backsheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a backsheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of non-woven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The department covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see department billing instructions for how to specify this when billing). The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit (see subsections (g), (h), (i), (j), (k), (l), and (m) of this section for product limitations). The following products cannot be used together:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Three hundred per month for a child three to eighteen years of age; and

(ii) Two hundred forty per month for an adult nineteen years of age and older.

(h) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred forty per month.

(i) Disposable briefs and pull-up pants (any size) are limited to:

(i) Three hundred per month for a child age three to eighteen years of age; and

(ii) One hundred fifty per month for an adult nineteen years of age and older.

(j) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(k) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred forty per month.

(l) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(8) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - two per month. This cannot be billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adaptor; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adaptor, for use with urinary leg bag or urostomy pouch. This cannot be billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. These cannot be billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. These cannot be billed in combination with: Other insertion trays without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. These cannot be billed in combination with: An insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston) - cannot be billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. These cannot be billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. These cannot be billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric). Allowed as replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. This cannot be billed in combination with: a latex urinary leg bag; urinary suspensory without leg bag; extension drainage tubing; or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. This cannot be billed in combination with: A leg strap; or an insertion tray with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. This cannot be billed in combination with an insertion tray with drainage bag and with or without catheter.

(9) Miscellaneous supplies:

(a) Bilirubin light therapy supplies - five days' supply. The department reimburses only when these are provided with a prior authorized bilirubin light.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Nontoxic gel (e.g., LiceOut TM) for use with lice combs - one bottle per twelve month period.

(f) Syringes and needles ("sharps") disposal container for home use, up to one gallon size - two per month.

(10) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period.

(b) Blood glucose monitor (specialized or home) - one in a three-year period.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap w/adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(f) Pneumatic compressor - one in a five-year period.

(g) Positioning car seat - one in a five-year period.

(11) Prosthetics and orthotics:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(12) Positioning devices:

(a) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(b) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(c) Adjustable standing frame (for child/adult thirty - sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - one in a five-year period.

(13) Beds, mattresses, and related equipment:

(a) Pressure pad, alternating with pump - one in a five-year period.

(b) Dry pressure mattress - one in a five-year period.

(c) Gel or gel-like pressure pad for mattress - one in a five-year period.

(d) Gel pressure mattress - one in a five-year period.

(e) Water pressure pad for mattress - one in a five-year period.

(f) Dry pressure pad for mattress - one in a five-year period.

(g) Mattress, inner spring - one in a five-year period.

(h) Mattress, foam rubber - one in a five-year period.

(i) Hospital bed, semi-electric - one in a ten-year period.

(j) Bedside rails - one in a ten-year period.

(14) Other patient room equipment:

(a) Patient lift, hydraulic, with seat or sling - one in a five-year period.

(b) Traction equipment - one in a five year period.

(c) Trapeze bars - one in a five-year period.

(d) Fracture frames - one in a five-year period.

(e) Transfer board or devices - one in a five-year period.

(15) Noninvasive bone growth/nerve stimulators:

(a) Transcutaneous electrical nerve stimulation device (TNS) - one in a five-year period.

(b) Osteogenesis stimulators - one in a five-year period.

(16) Communication devices - artificial larynx, any type - one in a five-year period.

(17) Ambulatory aids:

(a) Canes - one in a five-year period.

(b) Crutches - one in a five-year period.

(c) Walkers - one in a five-year period.

(18) Bathroom equipment:

(a) Commode chairs - one in a five-year period.

(b) Tub stool or bench - one in a five-year period.

(c) Transfer bench for tub or toilet - one in a five-year period.

(d) Bed pans - one in a five-year period.

(e) Urinals - one in a five-year period.

(f) Shower/commode chairs - one in a five-year period.

(g) Bath seats/chairs - one in a five-year period.

(h) Potty chairs - one in a five-year period.

(19) Blood monitoring:

(a) Sphygmomanometer/blood pressure apparatus - one in a five-year period.

(b) Automatic blood pressure monitor - one in a five-year period.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1150, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1150, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-082, § 388-543-1150, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-1150, filed 7/31/01, effective 8/31/01.]

WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. (1) The department pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered in this chapter, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200.

(2) The department pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and 388-543-1200.

(3) The department considers all requests for covered DME, related supplies and services, medical supplies, pros-

thetics, orthotics, and related services under the provisions of WAC 388-501-0165.

(4) The department evaluates a request for any DME item listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(5) The department specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

(a) Included as part of a managed care plan service package;

(b) Included in a waived program;

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries; or

(d) Requested for a child who is eligible for services under the EPSDT program. The department reviews these requests according to the provisions of chapter 388-534 WAC.

(6) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services are provided;

(b) Any service specifically excluded by statute;

(c) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the department for the client contributes to an increased utility bill (refer to the aging and disability services administration's (ADSA) COPES program for potential coverage);

(d) Hairpieces or wigs;

(e) Material or services covered under manufacturers' warranties;

(f) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(g) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(h) Prosthetic devices dispensed solely for cosmetic reasons (refer to WAC 388-531-0150 (1)(d));

(i) Home improvements and structural modifications, including but not limited to the following:

(i) Automatic door openers for the house or garage;

(ii) Saunas;

(iii) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(iv) Swimming pools;

(v) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(vi) Electrical rewiring for any reason;

(vii) Elevator systems and elevators; and

(viii) Lifts or ramps for the home; or

(ix) Installation of bathtubs or shower stalls.

(j) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(i) Back-packs, pouches, bags, baskets, or other carrying containers;

(ii) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(iii) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(iv) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(v) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(vi) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(A) Devices intended for amplifying voices (e.g., microphones);

(B) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to ADSA COPES or outpatient hospital programs for emergency response systems and services);

(C) Two-way radios; and

(D) Rental of related equipment or services;

(vii) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;

(viii) Ergonomic equipment;

(ix) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(x) Generators;

(xi) Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(xii) Computer utility bills, telephone bills, internet service, or technical support for computers or electronic notebooks;

(xiii) Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);

(xiv) Racing strollers/wheelchairs and purely recreational equipment;

(xv) Room fresheners/deodorizers;

(xvi) Bidet or hygiene systems, paraffin bath units, and shampoo rings;

(xvii) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(xviii) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(xix) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(k) Personal and **comfort items** that do not meet the DME definition, including but not limited to the following:

(i) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(ii) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers and sheets;

(iii) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(iv) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;

(v) Clothing protectors and other protective cloth furniture coverings;

(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves for bathtub;

(viii) Eating/feeding utensils;

(ix) Emesis basins, enema bags, and diaper wipes;

(x) Health club memberships;

(xi) Hot or cold temperature food and drink containers/holders;

(xii) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(xiii) Impotence devices;

(xiv) Insect repellants;

(xv) Massage equipment;

(xvi) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(xvii) Medicine cabinet and first-aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(xviii) Page turners;

(xix) Radio and television;

(xx) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(xxi) Toothettes and toothbrushes, waterpics, and periodontal devices whether manual, battery-operated, or electric.

(l) Certain wheelchair features and options are not considered by the department to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(i) Attendant controls (remote control devices);

(ii) Canopies, including those for strollers and other equipment;

(iii) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(iv) Identification devices (such as labels, license plates, name plates);

(v) Lighting systems;

(vi) Speed conversion kits; and

(vii) Tie-down restraints, except where medically necessary for client-owned vehicles.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-04-036, § 388-543-1300, filed 1/29/07, effective 3/1/07. Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1300, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1600 Items and services which require prior authorization. (1) The department bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA.) The department

considers all of the following when establishing utilization criteria:

(a) High cost;

(b) Potential for utilization abuse;

(c) Narrow therapeutic indication; and

(d) Safety.

(2) The department requires providers to obtain prior authorization for certain items and services, except for dual-eligible Medicare/Medicaid clients when Medicare is the primary payer. This includes, but is not limited to, the following:

(a) Augmentative communication devices (ACDs);

(b) Certain by report (BR) DME and supplies as specified in the department's published issuances, including billing instructions and numbered memoranda;

(c) Blood glucose monitors requiring special features;

(d) Certain equipment rentals and certain prosthetic limbs, as specified in the department's published issuances, including billing instructions and numbered memoranda;

(e) Decubitus care products and supplies;

(f) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;

(g) Equipment parts and labor charges for repairs or modifications and related services;

(h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;

(i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;

(j) Orthopedic shoes and selected orthotics;

(k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;

(l) Positioning car seats for children under five years of age;

(m) Transcutaneous electrical nerve stimulators, if the provider fails to meet the requirements in WAC 388-543-1900;

(n) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;

(o) Wheelchair-style shower/commode chairs;

(p) Other DME not specifically listed in the department's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and

(q) Limitation extensions.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1600, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1700 When the department covers rented DME. (1) The department's reimbursement amount for rented durable medical equipment (DME) includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(2) The department requires a dispensing provider to ensure the DME rented to a client is both of the following:

- (a) In good working order; and
- (b) Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.
- (3) The department considers rented equipment to be purchased after twelve months' rental unless one of the following apply:
 - (a) The equipment is restricted as rental only; or
 - (b) Other department published issuances state otherwise.
- (4) The department rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:
 - (a) Bilirubin lights for newborns at home with jaundice; and
 - (b) Electric breast pumps.
- (5) The department's minimum rental period for covered DME is one day.
- (6) If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:
 - (a) The department stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and
 - (b) The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.
- (7) The department stops paying for any rented equipment effective the date of a client's death. The department prorates monthly rentals as appropriate.
- (8) For a client who is eligible for both Medicaid and Medicare, the department pays only the client's coinsurance and deductibles. The department discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:
 - (a) The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or
 - (b) Medicare considers the equipment purchased.
- (9) The department does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a DSHS client.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1700, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1700, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2000 Wheelchairs. (1) The department bases its decisions regarding requests for wheelchairs on medical necessity and on a case-by-case basis.

(2) The following apply when the department determines that a wheelchair is medically necessary for six months or less:

- (a) If the client lives at home, the department rents a wheelchair for the client; or
- (b) If the client lives in a nursing facility, the nursing facility must provide a **house wheelchair** as part of the per diem rate paid by the aging and disability services administration (ADSA).
- (3) The department considers rental or purchase of a **manual wheelchair** for a home client who is nonambulatory or has limited mobility and requires a wheelchair to partici-

pate in normal daily activities. The department determines the type of manual wheelchair based on the following:

- (a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;
- (b) A standard lightweight wheelchair if the client's medical condition is such that the client:
 - (i) Cannot self-propel a standard weight wheelchair; or
 - (ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.
- (c) A high-strength lightweight wheelchair for a client:
 - (i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or
 - (ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.
- (d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:
 - (i) Support a person weighing up to three hundred pounds; or
 - (ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).
- (e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:
 - (i) Support a person weighing over three hundred pounds; or
 - (ii) Accommodate a seat width over twenty-two inches wide.
- (f) A rigid wheelchair for a client:
 - (i) With a medical condition that involves severe upper extremity weakness;
 - (ii) Who has a high level of activity; and
 - (iii) Who is unable to self-propel any of the above categories of wheelchair.
- (g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.
- (4) The department considers a **power-drive wheelchair** when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:
 - (a) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and
 - (b) A power-drive wheelchair will provide the client the only means of independent mobility; or
 - (c) A power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.
 - (d) All other circumstances will be considered based on medical necessity and on a case-by-case basis.
 - (e) The following additional information is required for a three or four-wheeled power-drive scooter/cart:
 - (i) The prescribing physician certifies that the client's condition is stable; and
 - (ii) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(5) The department considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

(6) In order to consider purchasing a wheelchair, the department requires the provider to submit the following information from the prescribing physician, physical therapist, or occupational therapist:

(a) Specific medical justification for the make and model of wheelchair requested;

(b) Define the degree and extent of the client's impairment (such as stage of decubitus, severity of spasticity or flaccidity, degree of kyphosis or scoliosis); and

(c) Documented outcomes of less expensive alternatives (aids to mobility) that have been tried by the client.

(7) In addition to the basic wheelchair, the department may consider wheelchair accessories or modifications that are specifically identified by the manufacturer as separate line item charges. The provider must submit specific medical justification for each line item, with the modification request.

(8) The department considers wheelchair modifications to a medically necessary wheelchair when the provider submits all of the following with the modification request:

(a) The make, model, and serial number of the wheelchair to be modified;

(b) The modification requested; and

(c) Specific information regarding the client's medical condition that necessitates the modification.

(9) The department may consider wheelchair repairs to a medically necessary wheelchair; the provider must submit to the department the make, model, and serial number of the wheelchair for which the repairs are requested.

(10) The department may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness;

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, the department requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

(iii) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-2000, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2800 Reusable and disposable medical supplies. (1) The department requires that a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC) prescribe reusable and disposable medical supplies. Except for dual eligible Medicare/Medicaid clients, the prescription must:

(a) Be dated and signed by the prescriber;

(b) Be less than six months in duration from the date the prescriber signs the prescription; and

(c) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(2) The department bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA). The department considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(3) The department requires a provider to obtain a limitation extension in order to exceed the stated limits for non-durable medical equipment and medical supplies. See WAC 388-501-0165.

(4) The department categorizes medical supplies and non-DME (MSE) as follows (see WAC 388-543-1150, 388-543-1600, and department's billing instructions for further information about specific limitations and requirements for PA and EPA):

(a) Antiseptics and germicides;

(b) Bandages, dressings, and tapes;

(c) Blood monitoring/testing supplies;

(d) Braces, belts, and supportive devices;

(e) Decubitus care products;

(f) Ostomy supplies;

(g) Pregnancy-related testing kits and nursing equipment supplies;

(h) Supplies associated with transcutaneous electrical nerve stimulators (TENS);

(i) Syringes and needles;

(j) Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and

(k) Miscellaneous supplies.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-2800, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-2800, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-2800, filed 7/31/01, effective 8/31/01; 01-01-078, § 388-543-2800, filed 12/13/00, effective 1/13/01.]

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-11-129, § 388-550-1000, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1050 Hospital services definitions.

The following definitions and abbreviations, those found in WAC 388-500-0005, Medical definitions, and definitions and abbreviations found in other sections of this chapter, apply to this chapter.

"Accommodation costs" means the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acquisition cost (AC)" means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice.

"Acute" means a medical condition of severe intensity with sudden onset. See WAC 388-550-2511 for the definition of "acute" for the acute physical medicine and rehabilitation (Acute PM&R) program.

"Acute care" means care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status (see WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at a department-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcoholism and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Administrative day rate" means the statewide Medicaid average daily nursing facility rate as determined by the department.

"Admitting diagnosis" means the medical condition before study, which is initially responsible for the client's admission to the hospital, as defined by the international classification of diseases, 9th revision, clinical modification (ICD-9-CM) diagnostic code, or with the current published ICD-CM coding guidelines used by the department.

"Advance directive" means a document, recognized under state law, such as a living will, executed by a client, that tells the client's health care providers and others about the client's decisions regarding his or her health care in the event the client should become incapacitated. (See WAC 388-501-0125.)

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcoholism and drug addiction treatment and support act (ADATSA)" means the law and the state-administered program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient DRG grouper (AP-DRG)" means a computer software program that determines the medical and surgical diagnosis related group (DRG) assignments.

"Allowable" means the calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

"Allowed amount" means the initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or charge," that the department allows as the basis for payment computation before final adjustments, deductions, and add-ons.

"Allowed charges" means the maximum amount for any procedure or service that the department allows as the basis for payment computation.

"Allowed covered charges" means the maximum amount of charges on a hospital claim recognized by the department as charges for "hospital covered service" and payment computation, after exclusion of any "nonallowed service or charge," and before final adjustments, deductions, and add-ons.

"Ambulatory surgery" means a surgical procedure that is not expected to require an inpatient hospital admission.

"Ancillary hospital costs" means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

"Ancillary services" means additional or supporting services provided by a hospital to a patient during the patient's hospital stay. These services include, but are not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" means the level of care required to best manage a client's illness or injury based on the severity of illness presentation and the intensity of services received.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Health, financial and billing records pertaining to billed services paid by the department through Medicaid, SCHIP, or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and health records, including mathematical computations and special studies conducted supporting the Medicare cost report (Form 2552-96), submitted to the department for the purpose of establishing program rates for payment to hospital providers.

"Audit claims sample" means a selection of claims reviewed under a defined audit process.

"Authorization" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

"Average hospital rate" means an average of hospital rates for any particular type of rate that the department uses.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Billed charge" means the charge submitted to the department by the provider.

"Blended rate" means a mathematically weighted average rate.

"Bordering city hospital" means a hospital located outside Washington state and located in one of the bordering cities listed in WAC 388-501-0175.

"BR" - See **"by report."**

"Budget neutrality" is a concept that means that hospital payments resulting from payment methodology changes and rate changes should be equal to what payments would have been if the payment methodology changes and rate changes were not implemented. (See also "budget neutrality factor.")

"Budget neutrality factor" is a factor used by the department to adjust conversion factors, per diem rates, and per case rates in order that modifications to the payment methodology and rates are budget neutral. (See also "budget neutrality.")

"Bundled services" means interventions that are integral to the major procedure and are not paid separately.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report (BR)" means a method of payment in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent,

time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping hospital staff members on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services which are usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" or **"capital costs"** means the component of operating costs related to capital assets, including, but not limited to:

- (1) Net adjusted depreciation expenses;
- (2) Lease and rentals for the use of depreciable assets;
- (3) The costs for betterment and improvements;
- (4) The cost of minor equipment;
- (5) Insurance expenses on depreciable assets;
- (6) Interest expense; and
- (7) Capital-related costs of related organizations that provide services to the hospital.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

"CARF" is the official name for commission on accreditation of rehabilitation facilities. CARF is an international, independent, nonprofit accreditor of human service providers and networks in the areas of aging services, behavioral health, child and youth services, employment and community services, and medical rehabilitation.

"Case mix" means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index (CMI)" means the arithmetical index that measures the average relative weight of all cases treated in a hospital during a defined period.

"Charity care" see chapter 70.170 RCW.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Client" means a person who receives or is eligible to receive services through department of social and health services (DSHS) programs.

"CMS" means Centers for Medicare and Medicaid Services.

"CMS PPS input price index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, measured by Global Insight's Data Resources, Inc. (DRI).

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's inpatient hospital data collection, tracking and reporting system.

"Contract hospital-selective contracting" means for dates of admission before July 1, 2007, a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's hospital selective contracting program. The department's hospital selective

contracting program no longer exists for admissions on and after July 1, 2007.

"Contract hospital" means a hospital contracted by the department to provide specific services.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has Medicaid claim charges for the services, but does not report costs in corresponding centers in its Medicare cost report.

"Cost report" see "Medicare cost report."

"Costs" mean department-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report."

"Cost-based conversion factor (CBCF)" means for dates of admission before August 1, 2007, a hospital-specific dollar amount that reflects a hospital's average cost of treating Medicaid and SCHIP clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid and SCHIP clients during a base period by the number of Medicaid and SCHIP discharges during that same period and adjusting for the hospital's case mix. See also **"hospital conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered charges" means billed charges submitted to the department on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" see "hospital covered service" and WAC 388-501-0060.

"Critical border hospital" means, on and after August 1, 2007, an acute care hospital located in a bordering city that the department has, through analysis of admissions and hospital days, designated as critical to provide elective health-care for the department's medical assistance clients.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Customary charge payment limit" means the limit placed by the department on aggregate DRG payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means an inpatient case with a date of admission before August 1, 2007, that requires the department to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."** The department's day outlier policy no longer exists for dates of admission on and after August 1, 2007.

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for inpatient claims with dates of admission before August 1, 2007, for a client

five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means for inpatient claims with dates of admission before August 1, 2007, the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Department" means the state department of social and health services (DSHS). As used in this chapter, department also means MAA, HRSA, or a successor administration that administers the state's Medicaid, SCHIP, and other medical assistance programs.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetes education program" means a comprehensive, multidisciplinary program of instruction offered by a department of health (DOH)-approved diabetes education provider to diabetic clients on dealing with diabetes. This includes instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share hospital (DSH) payment" means a supplemental payment(s) made by the department to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share hospital (DSH) program" is a program through which the department gives consideration to hospitals that serve a disproportionate number of low-income patients with special needs by making payment adjustment to eligible hospitals in accordance with legislative direction and established payment methods. See 1902(a)(13)(A)(iv) of the Social Security Act. See also WAC 388-550-4900 through 388-550-5400.

"Dispute conference" - See **"hospital dispute conference."**

"Distinct unit" means a Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a department-designated unit in a children's hospital.

"Division of alcohol and substance abuse (DASA)" is the division within DSHS responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction.

"DRG" - See **"diagnosis-related group."**

"DRG average length-of-stay" means for dates of admission on and after July 1, 2007, the department's average length-of-stay for a DRG classification established during a department DRG rebasing and recalibration project.

"DRG-exempt services" means services which are paid through other methodologies than those using inpatient Medicaid conversion factors, inpatient state-administered program conversion factors, cost-based conversion factors (CBCF) or negotiated conversion factors (NCF). Some examples are services paid using a per diem rate, a per case rate, or a ratio of costs-to-charges (RCC) rate.

"DRG payment" means the payment made by the department for a client's inpatient hospital stay. This DRG payment allowed amount is calculated by multiplying the conversion factor by the DRG relative weight assigned by the department to provider's inpatient claim before any outlier payment calculation.

"DRG relative weight" means the average cost or charge of a certain DRG classification divided by the average cost or charge, respectively, for all cases in the entire data base for all DRG classifications.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"DSHS" means the department of social and health services.

"Elective procedure or surgery" means a nonemergency procedure or surgery that can be scheduled at the client's and provider's convenience.

"Emergency medical condition" see WAC 388-500-0005.

"Emergency medical expense requirement (EMER)" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the psychiatric indigent inpatient (PII) program.

"Emergency room" or **"emergency facility"** or **"emergency department"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care.

"Emergency services" means healthcare services required by and provided to a patient after the sudden onset of

a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For department payment to a hospital, inpatient maternity services are treated as emergency services.

"Equivalency factor (EF)" means a factor that may be used by the department in conjunction with other factors to determine the level of a state-administered program payment. See WAC 388-550-4800.

"Exempt hospital—DRG payment method" means a hospital that for a certain patient category is reimbursed for services to medical assistance clients through methodologies other than those using DRG conversion factors.

"Exempt hospital—Hospital selective contracting program" means a hospital that is either not located in a selective contracting area or is exempted by the department from the selective contracting program. The department's hospital selective contracting program no longer exists for admissions on and after July 1, 2007.

"Expedited prior authorization (EPA)" means the department-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which department-acceptable indications, conditions, diagnoses, and/or department-defined criteria are applicable to a particular request for service.

"Expedited prior authorization (EPA) number" means an authorization number created by the provider that certifies that the department-published criteria for the medical/dental procedure or supply or services have been met.

"Experimental" means a procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 388-531-0050. A service is not "experimental" if the service:

- (1) Is generally accepted by the medical profession as effective and appropriate; and
- (2) Has been approved by the FDA or other requisite government body if such approval is required.

"Fee-for-service" means the general payment process the department uses to pay a hospital provider's claim for covered medical services provided to medical assistance clients when the payment for these services is through direct payment to the hospital provider, and is not the responsibility of one of the department's managed care organization (MCO) plans, or a mental health division designee.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Fixed per diem rate" means a daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

"Global surgery days" means the number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

"Graduate medical education costs" means the direct and indirect costs of providing medical education in teaching hospitals. See "direct medical education costs" and "indirect medical education costs."

"Grouper" - See **"all-patient DRG grouper (AP-DRG)."**

"Health and recovery services administration (HRSA)" means the successor administration to the medical assistance administration within the department, authorized by the department secretary to administer the acute care portion of Title XIX Medicaid, Title XXI SCHIP, and other medical assistance programs, with the exception of certain nonmedical services for persons with chronic disabilities.

"Health care team" means a group of health care providers involved in the care of a client.

"High-cost outlier" means, for dates of admission before August 1, 2007, a claim paid under the DRG payment method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a high-cost outlier, the billed charges, minus the noncovered charges reported on the claim, must exceed three times the applicable DRG payment and exceed thirty-three thousand dollars. The department's high-cost outliers are not applicable for dates of admission on and after July 1, 2007.

"High outlier claim—Medicaid/SCHIP DRG" means, for dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—Medicaid/SCHIP per diem" means, for dates of admission on and after August 1, 2007, a claim that is classified by the department as being allowed a high outlier payment that is paid under the per diem payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—State-administered program DRG" means, for dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"High outlier claim—State-administered program per diem" means, for dates of admission on or after August 1, 2007, a claim that is classified by the department as being allowed as a high outlier payment, that is paid under the per diem payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.

"Hospice" means a medically directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice.

"Hospital" means an entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a Medicare or state-certified distinct rehabilitation unit or a "psychiatric hospital" as defined in this section.

"Hospital base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Hospital base period costs" means costs incurred in, or associated with, a specified base period.

"Hospital conversion factor" means a hospital-specific dollar amount that reflects the average cost for a DRG paid case of treating Medicaid and SCHIP clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).

"Hospital covered service" means a service that is provided by a hospital, covered under a medical assistance program and is within the scope of an eligible client's medical assistance program.

"Hospital cost report" - See "cost report."

"Hospital dispute resolution conference" means an informal meeting for deliberation during a provider administrative appeal. For provider audit appeals, see chapter 388-502A WAC. For provider rate appeals, see WAC 388-501-0220.

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services measured by Global Insight's Data Resources, Inc. (DRI) and identified as the CMS PPS input price index.

"Hospital peer group" means the peer group categories established by the department for classification of hospitals:

(1) Peer Group A - hospitals identified by the department as rural hospitals (excludes all rural hospitals paid by the certified public expenditure (CPE) payment method and critical access hospital (CAH) payment method);

(2) Peer Group B - hospitals identified by the department as urban hospitals without medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);

(3) Peer Group C - hospitals identified by the department as urban hospitals with medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);

(4) Peer Group D - hospitals identified by the department as specialty hospitals and/or hospitals not easily assignable to the other five peer groups;

(5) Peer Group E - hospitals identified by the department as public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) payment program; and

(6) Peer Group F - hospitals identified by the department of health (DOH) as CAHs, and paid by the department using the CAH payment method.

"Hospital selective contracting program" or **"selective contracting"** means for dates of admission before July 1, 2007, a negotiated bidding program for hospitals within specified geographic areas to provide inpatient hospital services to medical assistance clients. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation adjustment. This adjustment is determined

by using the inflation factor method supported by the legislature. For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- (1) Disclosed and discussed the patient's diagnosis;
- (2) Offered the patient an opportunity to ask questions about the procedure and to request information in writing;
- (3) Given the patient a copy of the consent form;
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and
- (5) Given the patient oral information about all of the following:
 - (a) The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
 - (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
 - (c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient hospital admission" means an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's health record.

"Inpatient Medicaid conversion factor" means a dollar amount that represents selected hospitals' average costs of treating Medicaid and SCHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay Medicaid and SCHIP claims under the DRG payment method. See WAC 388-550-3450 for how this conversion factor is calculated.

"Inpatient services" means healthcare services provided directly or indirectly to a client subsequent to the client's inpatient hospital admission and prior to discharge.

"[I]npatient state-administered program conversion factor" means a dollar amount used as a rate reduced from the inpatient Medicaid conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims under the DRG payment method.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding).

"Length of stay (LOS)" means the number of days of inpatient hospitalization, calculated by adding the total number of days from the admission date to the discharge date, and subtracting one day.

"Length of stay extension request" means a request from a hospital provider for the department, or in the case of psychiatric admission, the appropriate mental health division designee, to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Long term acute care (LTAC) services" means inpatient intensive long-term care services provided in department-approved LTAC hospitals to eligible medical assistance clients who meet criteria for level 1 or level 2 services. See WAC 388-550-2565 through 388-550-2596.

"Low-cost outlier" means a case having a date of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than the greater of ten percent of the applicable DRG payment or four hundred and fifty dollars. The department's low-cost outliers are not applicable for dates of admission on and after August 1, 2007.

"Low income utilization rate (LIUR)" means a rate determined by a formula represented as $(A/B)+(C/D)$ in the same period in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies);

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services.

"Major diagnostic category (MDC)" means one of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG classification system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"MDC" - See **"major diagnostic category."**

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate (MIPUR)" means a ratio expressed by the following formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient

day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical assistance administration (MAA)" means the health and recovery services administration (HRSA), or a successor administration, within the department authorized by the department's secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI state children's health insurance program (SCHIP), and other medical assistance programs, with the exception of certain nonmedical services for persons with chronic disabilities.

"Medical assistance program" means any healthcare program administered through HRSA.

"Medical care services" means the state-administered limited scope of care provided to general assistance-unemployable (GAU) recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

"Medical education costs" means the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists.

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration.

"Medicare cost report" means the Medicare cost report (Form 2552-96), or successor document, completed and submitted annually by a hospital provider:

(1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

(2) To Medicaid to establish appropriate DRG and other rates for payment of services rendered.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medicaid.

"Medicare fee schedule (MFS)" means the official CMS publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) payment program.

"Medicare Part A" see WAC 388-500-0005.

"Medicare Part B" see WAC 388-500-0005.

"Medicare buy-in premium" - See **"buy-in premium."**

"Medicare payment principles" means the rules published in the federal register regarding payment for services provided to Medicare clients.

"Mental health division designee" or **"MHD designee"** means a professional contact person authorized by MHD, who operates under the direction of a regional support network (RSN) or a prepaid inpatient health plan (PIHP). See WAC 388-550-2600.

"Mentally incompetent" means a person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two to four patient beds.

"National drug code (NDC)" means the eleven digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The eleven-digit NDC is composed of a five-four-two grouping. The first five digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"Negotiated conversion factor (NCF)" means, for dates of admission before July 1, 2007, a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."** The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

"Newborn" or **"neonate"** or **"neonatal"** means a person younger than twenty-nine days old. However, a person who has been admitted to an acute care hospital setting as a newborn and is transferred to another acute care hospital setting is still considered a newborn for payment purposes.

"Nonallowed service or charge" means a service or charge that is not recognized for payment by the department, and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

"Noncontract hospital" means, for dates of admission before July 1, 2007 a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the hospital selective contracting program. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.

"Noncovered charges" means billed charges submitted to the department by a provider on a claim that are indicated by the provider on the claim as noncovered.

"Noncovered service or charge" means a service or charge that is not considered or paid by the department as a "hospital covered service," and cannot be billed to the client except under the conditions identified in WAC 388-502-0160.

"Nonemergency hospital admission" means any inpatient hospitalization of a patient who does not have an emergent medical condition, as defined in WAC 388-500-0005.

"Nonparticipating hospital" means a noncontract hospital. See **"noncontract hospital."**

"Observation services" means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"OPPS" - See **"outpatient prospective payment system."**

"OPPS adjustment" means the legislative mandated reduction in the outpatient adjustment factor made to account for the delay of OPPS implementation.

"OPPS outpatient adjustment factor" means the outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate.

"Orthotic device" or **"orthotic"** means a corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Out-of-state hospital" means any hospital located outside the state of Washington and outside the designated bordering cities in Oregon and Idaho (see WAC 388-501-0175). For medical assistance clients requiring psychiatric services, "out-of-state hospital" means any hospital located outside the state of Washington.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases. The department's outlier set-aside factor is not applicable for dates of admission on and after August 1, 2007.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year. The department's outlier set-aside pool is not applicable for dates of admission on and after August 1, 2007.

"Outliers" means cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a patient who is receiving health-care services in other than an inpatient hospital setting.

"Outpatient care" means healthcare provided other than inpatient services in a hospital setting.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient hospital services" means those healthcare services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient short stay" - See **"observation services"** and **"outpatient hospital services."**

"Outpatient surgery" means a surgical procedure that is not expected to require an inpatient hospital admission.

"Pain treatment facility" means a department-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts department clients.

"PAS length of stay (LOS)" means, for dates of admission before August 1, 2007, the average length of an inpatient hospital stay for patients based on diagnosis and age, as determined by the commission of professional and hospital activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)."**

"Patient consent" means the informed consent of the patient and/or the patient's legal guardian, as evidenced by

the patient's or guardian's signature on a consent form, for the procedure(s) to be performed upon or for the treatment to be provided to the patient.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means, for dates of admission before August 1, 2007, the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem rate" means a daily rate used to calculate payment for services provided as a "hospital covered service."

"Personal comfort items" means items and services which primarily serve the comfort or convenience of a client and do not contribute meaningfully to the treatment of an illness or injury.

"PM&R" - See **"Acute PM&R."**

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"PPS" see "prospective payment system."

"Primary care case management (PCCM)" means the coordination of healthcare services under the department's Indian health center or tribal clinic managed care program. See WAC 388-538-068.

"Principal diagnosis" means the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Prior authorization" means a process by which clients or providers must request and receive department or a department designee's approval for certain healthcare services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for payment to the provider. Expedited prior authorization and limitation extension are forms of prior authorization.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the commission of professional and hospital activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a payment that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prospective payment system (PPS)" means a system that sets payment rates for a predetermined period for defined services, before the services are provided. The payment rates

are based on economic forecasts and the projected cost of services for the predetermined period.

"Prosthetic device" or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

- (1) Artificially replace a missing portion of the body;
- (2) Prevent or correct physical deformity or malfunction;

or

- (3) Support a weak or deformed portion of the body.

"Psychiatric hospital" means a Medicare-certified distinct psychiatric unit, a Medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a Medicare-certified acute care hospital. Eastern state hospital and western state hospital are excluded from this definition.

"Psychiatric indigent inpatient (PII) program" means a state-administered program established by the department specifically for mental health clients identified in need of voluntary emergency inpatient psychiatric care by a mental health division designee. See WAC 388-865-0217.

"Psychiatric indigent person" means a person certified by the department as eligible for the psychiatric indigent inpatient (PII) program.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Ratable" means a factor used to calculate a reduction factor used to reduce Medicaid level rates to determine state administered program claim payment to hospitals.

"Ratio of costs-to-charges (RCC)" means a method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the factor or rate applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the department, and payment to the hospital for some DRG-exempt services.

"RCC" - See **"ratio of costs-to-charges."**

"Rebasing" means the process of recalculating the conversion factors, per diems, per case rates, or RCC rates using historical data.

"Recalibration" means the process of recalculating DRG relative weights using historical data.

"Regional support network (RSN)" means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC, to manage the provision of mental health services to medical assistance clients.

"Rehabilitation accreditation commission, The" - See "CARF."

"Rehabilitation units" means specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet department and/or Medicare criteria for distinct rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" means, for claims with dates of admission before July 1, 2007, hospitals that meet the following criteria during the hospital selective contracting (HSC) waiver application period:

- (1) Are located within Washington state;

- (2) Are more than ten miles from the nearest hospital in the HSC competitive area; and

- (3) Have fewer than seventy-five beds; and

- (4) Have fewer than five hundred Medicaid and SCHIP admissions within the previous waiver period.

"Reserve days" means the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means the services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" means a clinic that is located in areas designed by the bureau of census as rural and by the Secretary of the Department of Health and Human Services (DHHS), as medically underserved.

"Rural hospital" means an acute care healthcare facility capable of providing or assuring availability of inpatient and outpatient hospital health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means, for dates of admission before July 1, 2007, an area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid and SCHIP clients. This definition is not applicable for dates of admission on and after July 1, 2007.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Seven-day readmission" means the situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital within seven days.

"Special care unit" means a department of health (DOH) or Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" means children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

"Spendedown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department. See chapter 388-519 WAC.

"Stat laboratory charges" means the charges by a laboratory for performing a test or tests immediately. "Stat." is

the abbreviation for the Latin word "statim" meaning immediately.

"State children's health insurance program (SCHIP)" means the federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen.

"State plan" means the plan filed by the department with the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHHS), outlining how the state will administer Medicaid and SCHIP services, including the hospital program.

"Subacute care" means care provided to a patient which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed day" means a day in which a client is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the Centers for Medicare and Medicaid Services (CMS) for both acute care and skilled nursing services.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a procedure and service payment that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility or distinct unit to another.

"Transferring hospital" means the hospital or distinct unit that transfers a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC.

"Trauma care service" - See department of health's WAC 246-976-935.

"UB-04" is the uniform billing document required for use nationally, beginning on May 23, 2007, by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing third party payers for services provided to patients. This includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and/or modified by the Washington state payer group or the department.

"UB-92" is the uniform billing document discontinued for billing claims submitted on and after May 23, 2007.

"Unbundled services" means interventions that are not integral to the major procedure and that are paid separately.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured patient" means an individual who is not covered by insurance for provided inpatient and/or outpatient hospital services.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a health-care procedure or service, or the rate charged other contractors for the service if the general public is not served.

"Vendor rate increase" means an inflation adjustment determined by the legislature, that may be used to periodically increase rates for payment to vendors, including health-care providers, that do business with the state.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-052, § 388-550-1050, filed 6/28/07, effective 8/1/07; 04-20-057, § 388-550-1050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-043, § 388-550-1050, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-1050, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652, 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1100 Hospital care—General. (1) The department:

(a) Pays for the admission of an eligible medical assistance client to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered according to WAC 388-501-0050, 388-501-0060 and 388-501-0065;

(ii) Are medically necessary as defined in WAC 388-500-0005;

(iii) Are determined according to WAC 388-501-0165 when prior authorization is required;

(iv) Are authorized when required under this chapter; and

(v) Meet applicable state and federal requirements.

(b) For hospital admissions, defines "attending physician" as the client's primary care provider, or the primary provider of care to the client at the time of admission.

(2) Medical record documentation of hospital services must meet the requirements in WAC 388-502-0020.

(3) The department:

(a) Pays for a hospital covered service provided to an eligible medical assistance client enrolled in a department managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the department and meets prior authorization requirements. (See WAC 388-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to a medical assistance client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 388-550-4600 and 388-550-4700 apply. The department's selective contracting program and selective contracting pay-

ment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The department pays up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the chemical-using pregnant (CUP) women program.

See WAC 388-533-0701 through 388-533-0730.

(5) The department pays for inpatient hospital detoxification of acute alcohol or other drug intoxication when the services are provided to an eligible client:

(a) In a detoxification unit in a hospital that has a detoxification provider agreement with the department to perform these services and the services are approved by the division of alcohol and substance abuse (DASA); or

(b) In an acute hospital and all of the following criteria are met:

(i) The hospital does not have a detoxification specific provider agreement with DASA;

(ii) The hospital provides the care in a medical unit;

(iii) Nonhospital based detoxification is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from a regional support network (RSN) or a mental health division (MHD) designee as an inpatient stay is not indicated;

(v) The client's stay qualifies as an inpatient stay;

(vi) The client is not participating in the department's chemical-using pregnant (CUP) women program; and

(vii) The client's principal diagnosis meets the department's medical inpatient detoxification criteria listed in the department's published billing instructions.

(6) The department covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

(a) Are provided in accordance with chapter 388-535 WAC; and

(b) Are billed on the American Dental Association (ADA) or health care financing administration (HCFA) claim form.

(7) The department pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room, when:

(a) The covered dental-related services are medically necessary and provided in accordance with chapter 388-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least one of the following is true:

(i) The dental-related service(s) is provided to an eligible medical assistance client on an emergency basis;

(ii) The client is eligible under the division of developmental disability program;

(iii) The client is age eight or younger; or

(iv) The dental service is prior authorized by the department.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 388-550-2600.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-053, § 388-550-1100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090

and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-1100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a client eligible under a medical assistance program that is paid by the department's fee-for-services payment system must be within the scope of the client's medical assistance program. Coverage restriction includes, but is not limited to the following:

(1) Clients enrolled with the department's managed care organization (MCO) plans are subject to the respective plan's policies and procedures for coverage of hospital services;

(2) Clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsections (1) and (2) of this section, see WAC 388-538-100.

(4) Coverage for psychiatric indigent inpatient (PII) clients is limited to voluntary inpatient psychiatric hospital services, subject to the conditions and limitations of WAC 388-865-0217 and this chapter:

(a) Out-of-state healthcare is not covered for clients under the PII program; and

(b) Bordering city hospitals and critical border hospitals are not considered instate hospitals for PII program claims.

(5) Healthcare services provided by a hospital located out-of-state are:

(a) Not covered for clients eligible under the medical care services (MCS) program. However, clients eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible Medicaid and SCHIP clients without prior authorization, based on the medical necessity and utilization review standards and limits established by the department.

(ii) Nonemergency out-of-state care for Medicaid and SCHIP clients when prior authorized by the department based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC 388-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible Medicaid and SCHIP clients based on authorization by a mental health division (MHD) designee.

(6) See WAC 388-550-1100 for hospital services for chemical-using pregnant (CUP) women.

(7) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a MHD designee. See WAC 388-550-2600.

(8) For clients eligible for both Medicare and Medicaid (dual eligibles), the department pays deductibles and coinsurance, unless the client has exhausted his or her Medicare Part A benefits. If Medicare benefits are exhausted, the depart-

ment pays for hospitalization for such clients subject to department rules. See also chapter 388-502 WAC.

(9) The department does not pay for covered inpatient hospital services for a medical assistance client:

(a) Who is discharged from a hospital by a physician because the client no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(10) If the hospital's utilization review committee determines the client's stay is beyond the period of medical necessity, as described in subsection (9) of this section, the hospital must:

(a) Inform the client in a written notice that the department is not responsible for payment (42 CFR 456);

(b) Comply with the requirements in WAC 388-502-0160 in order to bill the client for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the department.

(11) Other coverage restrictions, as determined by the department.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1300 Revenue code categories and subcategories. (1) Revenue code categories and subcategories listed in this chapter are published in the UB-92 and/or UB-04 National Uniform Billing Data Element Specifications Manual.

(2) The department requires a hospital provider to report and bill all hospital services provided to medical assistance clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1300, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-044, § 388-550-1300, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals. (1) The department requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) codes in addition to the required revenue codes on an outpatient claim line when using any of the following revenue code categories and subcategories:

(a) "IV therapy," only subcategories "general classification" and "infusion pump";

(b) "Medical/surgical supplies and devices," only subcategory "other supplies/devices";

(c) "Oncology";

(d) "Laboratory";

(e) "Laboratory pathological";

(f) "Radiology - diagnostic";

(g) "Radiology - therapeutic and/or chemotherapy administration";

(h) "Nuclear medicine";

(i) "CT scan";

(j) "Operating room services," only subcategories "general classification" and "minor surgery";

(k) "Blood and blood components";

(l) Administration, processing, and storage for blood components";

(m) "Other imaging services";

(n) "Respiratory services";

(o) "Physical therapy";

(p) "Occupational therapy";

(q) "Speech therapy - language pathology";

(r) "Emergency room," only subcategories "general classification" and "urgent care";

(s) "Pulmonary function";

(t) "Audiology";

(u) "Cardiology";

(v) "Ambulatory surgical care";

(w) "Clinic," only subcategories "general classification" and "other clinic";

(x) "Magnetic resonance technology (MRT)";

(y) "Medical/surgical supplies - extension," only subcategory "surgical dressings";

(z) "Pharmacy - extension" subcategories "Erythropoietin (EPO) less than ten thousand units," "Erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(aa) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(bb) "EKG/ECG (electrocardiogram)";

(cc) "EEG (electroencephalogram)";

(dd) "Gastro-intestinal services";

(ee) "Specialty room - treatment/observation room," subcategory "treatment room and observation room";

(ff) "Telemedicine," only subcategory "other telemedicine";

(gg) "Extra-corporeal shock wave therapy (formerly lithotripsy)";

(hh) "Acquisition of body components," only subcategories "general classification" and "cadaver donor";

(ii) "Hemodialysis - outpatient or home," only subcategory "general classification";

(jj) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(kk) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," only subcategory "general classification";

(ll) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(mm) "Miscellaneous dialysis," only subcategories "general classification" and "ultrafiltration";

(nn) "Behavioral health treatments/services," only subcategory "electroshock therapy";

(oo) "Other diagnostic services";

(pp) "Other therapeutic services," only subcategories "general classification," "cardiac rehabilitation," and "other therapeutic service"; and

(qq) Other revenue code categories and subcategories identified and published by the department.

(2) For an outpatient claim line requiring a CPT or HCPCS code(s), the department denies payment if the required code is not reported on the line.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1350, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-044, § 388-550-1350, filed 9/10/03, effective 10/11/03.]

WAC 388-550-1400 Covered and noncovered revenue codes categories and subcategories for inpatient hospital services. Subject to the limitations and restrictions listed, this section identifies covered and noncovered revenue code categories and subcategories for inpatient hospital services.

(1) The department pays for an inpatient hospital covered service in the following revenue code categories and subcategories when the hospital provider accurately bills:

(a) "Room & board - private (one bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(b) "Room & board - semi-private (two bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(c) "Room & board - semi-private - (three and four beds)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(d) "Room & board - deluxe private," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(e) "Nursery," only subcategories "general classification," "newborn - level I," "newborn - level II," "newborn - level III," and "newborn - level IV";

(f) "Intensive care unit," only subcategories "general classification," "surgical," "medical," "pediatric," "intermediate ICU," "burn care," and "trauma";

(g) "Coronary care unit," only subcategories "general classification," "myocardial infarction," "pulmonary care," and "intermediate CCU";

(h) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(i) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery" and "IV therapy/supplies";

(j) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(k) "Oncology," only subcategory "general classification";

(l) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "nonroutine dialysis," "hematology," "bacteriology & microbiology," and "urology";

(m) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(n) "Radiology - diagnostic," only subcategories "general classification," "angiocardiology," "arthrography," "arteriography," and "chest X ray";

(o) "Radiology - therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy administration - injected," "chemotherapy administration - oral," "radiation therapy," and "chemotherapy administration - IV";

(p) "Nuclear medicine," only subcategories "general classification," "diagnostic," "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(q) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(r) "Operating room services," only subcategories "general classification" and "minor surgery";

(s) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(t) "Administration, processing and storage for blood and blood component," only subcategories "general classification" and "administration";

(u) "Other imaging services," only subcategories "general classification," "diagnostic mammography," "ultrasound," and "positron emission tomography";

(v) "Respiratory services," only subcategories "general classification," "inhalation services" and "hyper baric oxygen therapy";

(w) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(x) "Speech therapy-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(y) "Emergency room," only subcategories "general, urgent care classification" and "urgent care";

(z) "Pulmonary function," only subcategory "general classification";

(aa) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(bb) "Ambulatory surgical care," only subcategory "general classification";

(cc) "Outpatient services," only subcategory "general classification";

(dd) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," "MRA - lower extremities," and "MRA-other";

(ee) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(ff) "Pharmacy-extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(gg) "Cast room," only subcategory "general classification";

(hh) "Recovery room," only subcategory "general classification";

(ii) "Labor room/delivery," only subcategory "general classification," "labor," "delivery," and "birthing center";

(jj) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(kk) "EEG (Electroencephalogram)," only subcategory "general classification";

(ll) "Gastro-intestinal services," only subcategory "general classification";

(mm) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(nn) "Extra-corporeal shock wave therapy (formerly lithotripsy)," only subcategory "general classification";

(oo) "Inpatient renal dialysis," only subcategories "general classification," "inpatient hemodialysis," "inpatient peritoneal (non-CAPD)," "inpatient continuous ambulatory peritoneal dialysis (CAPD)," and "inpatient continuous cycling peritoneal dialysis (CCPD)";

(pp) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(qq) "Miscellaneous dialysis," only subcategory "ultra filtration";

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," and "pregnancy test"; and

(ss) "Other therapeutic services," only subcategory "general classification."

(2) The department pays for an inpatient hospital covered service in the following revenue code subcategories only when the hospital provider is approved by the department to provide the specific service:

(a) "All inclusive rate," only subcategory "all-inclusive room & board plus ancillary";

(b) "Room & board - private (one bed)," only subcategory "psychiatric";

(c) "Room & board - semi-private (two beds)," only subcategories "psychiatric," "detoxification," "rehabilitation," and "other";

(d) "Room & board - semi-private three and four beds," only subcategories "psychiatric" and "detoxification";

(e) "Room & board - deluxe private," only subcategory "psychiatric";

(f) "Room & board - ward," only subcategories "general classification" and "detoxification";

(g) "Room & board - other," only subcategories "general classification" and "other";

(h) "Intensive care unit," only subcategory "psychiatric";

(i) "Coronary care unit," only subcategory "heart transplant";

(j) "Operating room services," only subcategories "organ transplant-other than kidney" and "kidney transplant";

(k) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate" and "evaluation or reevaluation";

(l) "Clinic," only subcategory "chronic pain clinic";

(m) "Ambulance," only subcategory "neonatal ambulance services";

(n) "Behavioral health treatment/services," only subcategory "electroshock treatment"; and

(o) "Behavioral health treatment/services - extension," only subcategory "rehabilitation."

(3) The department pays revenue code category "occupational therapy," subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation" when:

(a) A client is in an acute PM&R facility;

(b) A client is age twenty or younger; or

(c) The diagnosis code is listed in the department's published billing instructions.

(4) The department does not pay for inpatient hospital services in the following revenue code categories and subcategories:

(a) "All inclusive rate," subcategory "all-inclusive room and board";

(b) "Room & board - private (one bed)" subcategories "hospice," "detoxification," "rehabilitation," and "other";

(c) "Room & board - semi-private (two bed)," subcategory "hospice";

(d) "Room & board - semi-private - (three and four beds)," subcategories "hospice," "rehabilitation," and "other";

(e) "Room & board - deluxe private," subcategories "hospice," "detoxification," "rehabilitation," and "other";

(f) "Room & board - ward," subcategories "medical/surgical/gyn," "OB," "pediatric," "psychiatric," "hospice," "oncology," "rehabilitation," and "other";

(g) "Room & board - other," subcategories "sterile environment," and "self care";

(h) "Nursery," subcategory "other nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit," subcategory "other intensive care";

(l) "Coronary care unit," subcategory "other coronary care";

(m) "Special charges";

(n) "Incremental nursing charge";

(o) "All inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotics devices," "oxygen - take home," and "other supplies/devices";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)";

(u) "Laboratory," subcategories "renal patient (home)," and "other laboratory";

(v) "Laboratory pathology," subcategory "other laboratory - pathological";

(w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - therapeutic," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategory "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture," and "other anesthesia";

(cc) "Blood and blood components";

(dd) "Administration, processing and storage for blood and blood components," subcategory "other processing and storage";

(ee) "Other imaging services," subcategories "screening mammography," and "other imaging services";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy," subcategory "other physical therapy";

(hh) "Occupational therapy," subcategory "other occupational therapy";

(ii) "Speech therapy-language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening," and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services," subcategory "other outpatient service";

(pp) "Clinic," subcategories "general classification," "dental clinic," "psychiatric clinic," "OB-gyn clinic," "pediatric clinic," "urgent care clinic," "family practice clinic," and "other clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance," subcategories "general classification," "supplies," "medical transport," "heart mobile," "oxygen," "air ambulance," "pharmacy," "telephone transmission EKG," and "other ambulance";

(tt) "Home health (HH) skilled nursing";

(uu) "Home health (HH) medical social services";

(vv) "Home health (HH) - aide";

(ww) "Home health (HH) - other visits";

(xx) "Home health (HH) - units of service";

(yy) "Home health (HH) - oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";

(aaa) "Medical" "medical/surgical supplies - extension," subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Specialty room - treatment/observation room," subcategory "other specialty rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine";

(ppp) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis," subcategory "other inpatient dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - outpatient or home";

(ttt) "Peritoneal dialysis - outpatient or home";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home";

(www) "Miscellaneous dialysis," subcategories "general classification," "home dialysis aid visit," and "other miscellaneous dialysis";

(xxx) Behavioral health treatments/services, subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive outpatient services - chemical dependency," "community behavioral health program (day treatment)";

(yyy) Behavioral health treatment/services - (extension), subcategories "rehabilitation," "partial hospitalization - less intensive," "partial hospitalization - intensive," "individual therapy," "group therapy," "family therapy," "bio feedback," "testing," and "other behavioral health treatment/services";

(zzz) "Other diagnostic services," subcategories "general classification," "pap smear," "allergy test," and "other diagnostic service";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services," subcategories "recreational therapy," "cardiac rehabilitation," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," and "other therapeutic services";

(cccc) "Other therapeutic services - extension," subcategories "athletic training" and "kinesiotherapy";

(dddd) "Professional fees";

(eeee) "Patient convenience items"; and

(ffff) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1400, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-045, § 388-550-1400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-1400, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services. (1) The department pays for an outpatient hospital covered service in the following revenue code category

ries and subcategories when the hospital provider accurately bills:

(a) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(b) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery," and "IV therapy/supplies";

(c) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant," and "other supplies/devices";

(d) "Oncology," only subcategory "general classification";

(e) "Durable medical equipment (other than renal)," only subcategory "general classification";

(f) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "renal patient (home)," "nonroutine dialysis," "hematology," "bacteriology and microbiology," and "urology";

(g) "Laboratory pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(h) "Radiology - diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X ray";

(i) "Radiology - therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(j) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(k) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(l) "Operating room services," only subcategories "general classification" and "minor surgery";

(m) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(n) "Administration, processing and storage for blood and blood components," only subcategories "general classification" and "administration";

(o) "Other imaging," only subcategories "general classification," "diagnostic mammography," "ultrasound," "screening mammography," and "positron emission tomography";

(p) "Respiratory services," only subcategories "general classification," "inhalation services," and "hyper baric oxygen therapy";

(q) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(r) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(s) "Speech therapy-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(t) "Emergency room," only subcategories "general classification" and "urgent care";

(u) "Pulmonary function," only subcategory "general classification";

(v) "Audiology," only subcategories "general classification," "diagnostic," and "treatment";

(w) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(x) "Ambulatory surgical care," only subcategory "general classification";

(y) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," "MRA - lower extremities" and "MRA-other";

(z) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(aa) "Pharmacy - extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(bb) "Cast room," only subcategory "general classification";

(cc) "Recovery room," only subcategory "general classification";

(dd) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(ee) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(ff) "EEG (Electroencephalogram)," only subcategory "general classification";

(gg) "Gastro-intestinal services," only subcategory "general classification";

(hh) "Specialty room - treatment/observation room," only subcategories "treatment room," and "observation room";

(ii) "Telemedicine," only subcategory "other telemedicine";

(jj) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "general classification";

(kk) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(ll) "Hemodialysis - outpatient or home," only subcategory "general classification";

(mm) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(nn) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," only subcategory "general classification";

(oo) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(pp) "Miscellaneous dialysis," only subcategories "general classification," and "ultra filtration";

(qq) "Behavioral health treatments/services," only subcategory "electroshock treatment"; and

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyogram," "pap smear," and "pregnancy test."

(2) The department pays for an outpatient hospital covered service in the following revenue code subcategories only when the outpatient hospital provider is approved by the department to provide the specific service(s):

(a) "Clinic," subcategories "general classification," "dental clinic," and "other clinic"; and

(b) "Other therapeutic services," subcategories, "general classification," "education/training," "cardiac rehabilitation," and "other therapeutic service."

(3) The department does not pay for outpatient hospital services in the following revenue code categories and subcategories:

- (a) "All inclusive rate";
- (b) "Room & board - private (one bed)";
- (c) "Room & board - semi-private (two beds)";
- (d) "Room & board - semi-private (three and four beds)";
- (e) "Room & board - deluxe private";
- (f) "Room & board - ward";
- (g) "Room & board - other";
- (h) "Nursery";
- (i) "Leave of absence";
- (j) "Subacute care";
- (k) "Intensive care unit";
- (l) "Coronary care unit";
- (m) "Special charges";
- (n) "Incremental nursing charge rate";
- (o) "All inclusive ancillary";
- (p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";
- (q) "IV therapy," subcategory "other IV therapy";
- (r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotic devices," and "oxygen - take home";
- (s) "Oncology," subcategory "other oncology";
- (t) "Durable medical equipment (other than renal)," subcategories "rental," "purchase of new DME," "purchase of used DME," "supplies/drugs for DME effectiveness (home health agency only)," and "other equipment";
- (u) "Laboratory," subcategory "other laboratory";
- (v) "Laboratory pathology," subcategory "other laboratory pathological";
- (w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";
- (x) "Radiology - therapeutic and/or chemotherapy administration," subcategory "other radiology - therapeutic";
- (y) "Nuclear medicine," subcategory "other nuclear medicine";
- (z) "CT scan," subcategory "other CT scan";
- (aa) "Operating room services," subcategories "organ transplant - other than kidney," "kidney transplant," and "other operating room services";
- (bb) "Anesthesia," subcategories "acupuncture" and "other anesthesia";
- (cc) "Blood and blood components";
- (dd) "Administration, processing and storage for blood and blood component," subcategory "other processing and storage";

(ee) "Other imaging," subcategory "other imaging service";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy services," subcategory "other physical therapy";

(hh) "Occupational therapy services," subcategory "other occupational therapy";

(ii) "Speech therapy-language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening" and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology," subcategory "other audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services";

(pp) "Clinic," subcategories "chronic pain center," "psychiatric clinic," "OB-GYN clinic," "pediatric clinic," "urgent care clinic," and "family practice clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance";

(tt) "Home health (HH) - skilled nursing";

(uu) "Home health (HH) - medical social services";

(vv) "Home health (HH) - aide";

(ww) "Home health (HH) - other visits";

(xx) "Home health (HH) - units of service";

(yy) "Home health (HH) - oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategory "other MRT";

(aaa) "Medical/surgical supplies - extension," only subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Speciality room - treatment/observation room," subcategories "general classification" and "other speciality rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine," subcategory "general classification";

(ppp) "Extra-corporal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - outpatient or home," subcategories "hemodialysis/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient hemodialysis (home)";

(ttt) "Peritoneal dialysis - outpatient or home," subcategories "peritoneal/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)" "support services (home)," and "other outpatient peritoneal dialysis (home)";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," subcategories "CAPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)" "support services (home)," and "other outpatient CAPD (home)";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," subcategories "CCPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient CCPD (home)";

(www) "Miscellaneous dialysis," subcategories "home dialysis aid visit" and "other miscellaneous dialysis";

(xxx) "Behavioral health treatments/services," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," "intensive outpatient services - psychiatric," "intensive outpatient services -chemical dependency," and "community behavioral health program (day treatment)";

(yyy) "Behavioral health treatment/services (extension)";

(zzz) "Other diagnostic services," subcategories "allergy test" and "other diagnostic services";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services - extension," subcategories "recreational therapy," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," "athletic training," and "kinesiotherapy";

(cccc) "Professional fees";

(dddd) "Patient convenience items"; and

(eeee) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1500, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-046, § 388-550-1500, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1600 Specific items/services not covered. The department does not pay for an inpatient or outpatient hospital service, treatment, equipment, drug or supply that is not listed or referred to as a covered service in this chapter. The following list of noncovered items and services is not intended to be all inclusive. Noncovered items and services include, but are not limited to:

(1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;

(2) Telephone/telegraph services or television/radio rentals;

(3) Medical photographic or audio/videotape records;

(4) Crisis counseling;

(5) Psychiatric day care;

(6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;

(7) Standby personnel and travel time;

(8) Routine hospital medical supplies and equipment such as bed scales;

(9) Handling fees and portable X-ray charges;

(10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;

(11) Cafeteria charges; and

(12) Services and supplies provided to nonpatients, such as meals and "father packs."

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1600, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services.

(1) This section applies to the department's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to medical assistance clients receiving services through the fee-for-service program. For clients eligible under other medical assistance programs, see chapter 388-538 WAC for managed care organizations, chapters 388-800 and 388-810 WAC for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), and chapter 388-865 WAC for mental health treatment programs coordinated through the mental health division or its designee). See chapter 388-546 WAC for transportation services.

(2) All hospital services paid for by the department are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The department will deny, recover, or adjust hospital payments if the department or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The department may perform one or more types of UR described in subsection (6) of this section.

(6) The department's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review"—An evaluation performed by the department or its designee during a client's

course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review"—An evaluation performed by the department or its designee prior to the provision of healthcare services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"—An evaluation performed by the department or its designee following the provision of healthcare services that includes both a post-payment retrospective UR (performed after healthcare services are provided and paid), and a prepayment retrospective UR (performed after healthcare services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the department or its designee notifies the appropriate oversight entity if either of the following is identified:

- (a) A quality of care concern; or
- (b) Fraudulent conduct.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1700, filed 6/22/07, effective 8/1/07; 04-20-058, § 388-550-1700, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-1700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1800 Hospital specialty services not requiring prior authorization. The department pays for certain specialty services without requiring prior authorization when such services are provided consistent with department medical necessity and utilization review standards. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2) under the conditions established in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1800, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1900 Transplant coverage. (1) The department pays for medically necessary transplant procedures only for eligible medical assistance clients who are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the alien emergency medical (AEM) program are not eligible for transplant coverage.

(2) The department covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the department as a "center of excellence" for transplant procedures and meet that hospital's cri-

teria for establishing appropriateness and the medical necessity of the procedures:

- (a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas and small bowel;
- (b) Bone marrow and peripheral stem cell (PSC);
- (c) Skin grafts; and
- (d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department pays facility charges only to those hospitals that meet the standards and conditions:

- (a) Established by the department; and
- (b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department pays for skin grafts and corneal transplants to any qualified hospital, subject to the limitations in this chapter.

(5) The department deems organ procurement fees as being included in the payment to the transplant hospital. The department may make an exception to this policy and pay these fees separately to a transplant hospital when an eligible medical client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department, without requiring prior authorization, pays for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department requires prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department does not pay for experimental transplant procedures. In addition, the department considers as experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department pays for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

(9) The department pays for bone marrow, PSC, skin grafts and corneal transplants when medically necessary.

(10) The department may conduct a post-payment retrospective utilization review as described in WAC 388-550-1700, and may adjust the payment if the department determines the criteria in this section are not met.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-1900, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2100 Requirements—Transplant hospitals. This section applies to requirements for hospitals that perform the department approved transplants described in WAC 388-550-1900(2).

(1) The department requires instate transplant hospitals to meet the following requirements in order to be paid for

transplant services provided to medical assistance clients. A hospital must have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of transplant procedure(s) to be performed, except that the department does not require CON approval for a hospital that provides peripheral stem cell (PSC), skin graft or corneal transplant services;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that the department does not require UNOS approval for a hospital that provides PSC, skin graft or corneal transplant services; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the hospital proposes to perform.

(2) The department requires an out-of-state transplant center, including bordering city and critical border hospitals, to be a Medicare-certified transplant center in a hospital participating in that state's Medicaid program. All out-of-state transplant services, excluding those provided in department approved centers of excellence (COE) in bordering city and critical border hospitals, must be prior authorized.

(3) The department considers a hospital for approval as a transplant center of excellence when the hospital submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members must be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department considers this requirement met when the hospital submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams must include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times; and

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients.

(c) Other resources that the transplant hospital must have include:

(i) Pathology resources for studying and reporting the pathological responses of transplantation;

(ii) Infectious disease services with both the professional skills and the laboratory resources needed to identify and manage a whole range of organisms; and

(iii) Social services resources.

(d) An organ procurement coordinator;

(e) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(f) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(g) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable

manner conducive to an optimal or successful patient outcome;

(h) Extensive blood bank support;

(i) Patient management plans and protocols; and

(j) Written policies safeguarding the rights and privacy of patients.

(4) In addition to the requirements of subsection (3) of this section, the transplant hospital must:

(a) Satisfy the annual volume and survival rates criteria for the particular transplant procedures performed at the hospital, as specified in WAC 388-550-2200(2).

(b) Submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the hospital:

(i) Participates in the national donor procurement program and network; and

(ii) Systematically collects and shares data on its transplant program(s) with the network.

(5) The department applies the following specific requirements to a PSC transplant hospital:

(a) A PSC transplant hospital must be a department approved COE to perform any of the following PSC services:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A PCS transplant hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

(6) The department does not pay a PSC transplant hospital for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2100, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2200 Transplant requirements—COE. (1) The department measures the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department applies these criteria to a hospital during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE must meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

- (c) Ten or more heart-lung transplants;
- (d) Twelve or more liver transplants;
- (e) Twenty-five or more kidney transplants;
- (f) Eighteen or more pancreas transplants;
- (g) Eighteen or more kidney-pancreas transplants;
- (h) Ten or more bone marrow transplants; and
- (i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant hospital within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for conditional approval as a transplant COE. The department considers the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the department of health (DOH).

(4) An in-state hospital granted conditional approval by the department as a transplant COE must meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department must automatically revoke such conditional approval for any hospital which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The hospital submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence must meet Medicare's survival rate requirements for the transplant procedure(s) performed at the hospital.

(6) A transplant COE must submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (Form 2552-96) documentation showing:

(a) The numbers of transplants performed at the hospital during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7) Transplant hospitals must:

(a) Submit to the department, within sixty days of the date of the hospital's approval as a COE, a complete set of the comprehensive patient selection criteria and treatment protocols used by the hospital for each transplant procedure it has been approved to perform.

(b) Submit to the department annual updates to the documents listed in subsection (a) of this section, or whenever the hospital makes a change to the criteria and/or protocols.

(c) Notify the department if no changes occurred during a reporting period.

(8) The department evaluates compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by a transplant COE in accordance with subsection (7) of this section. The department terminates a hospital's designation as a transplant COE if a review or audit finds that hospital in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9) The department:

(a) Provides notification to a transplant COE it finds in noncompliance with subsection (8) of this section, and may allow from the date of notification sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) Does not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-502-0030;

(c) Requires, within six months of submitting a plan to correct a breach of compliance, a center to report that:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance exists.

(10) The department periodically reviews the list of approved transplant COEs. The department may limit the number of hospitals it designates as a transplant COE or contracts with to provide services to medical assistance clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department pays a department-approved COE for covered transplant procedures using methods identified in chapter 388-550 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-2200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2301 Hospital and medical criteria requirements for bariatric surgery.

(1) The department pays a hospital for bariatric surgery and bariatric surgery-related services only when the surgery is provided in an inpatient hospital setting and only when:

(a) The client qualifies for bariatric surgery by successfully completing all requirements under WAC 388-531-1600;

(b) The client continues to meet the criteria to qualify for bariatric surgery under WAC 388-531-1600 up to the actual surgery date;

(c) The hospital providing the bariatric surgery and bariatric surgery-related services meets the requirements in this section and other applicable WAC; and

(d) The hospital receives prior authorization from the department prior to performing a bariatric surgery for a medical assistance client.

(2) A hospital must meet the following requirements in order to be paid for bariatric surgery and bariatric surgery-related services provided to an eligible medical assistance client. The hospital must:

(a) Be approved by the department to provide bariatric surgery and bariatric surgery-related services and;

(i) For dates of admission on or after July 1, 2007, be located in Washington state or approved bordering cities (see WAC 388-501-0175).

(ii) For dates of admission on or after July 1, 2007, be located in Washington state, or be a department-designated critical border hospital.

(b) Have an established bariatric surgery program in operation under which at least one hundred bariatric surgery procedures have been performed. The program must have been in operation for at least five years and be under the direction of an experienced board-certified surgeon. In addition, department requires the bariatric surgery program to:

- (i) Have a mortality rate of two percent or less;
- (ii) Have a morbidity rate of fifteen percent or less;
- (iii) Document patient follow-up for at least five years postsurgery;

(iv) Have an average loss of at least fifty percent of excess body weight achieved by patients at five years postsurgery; and

(v) Have a reoperation or revision rate of five percent or less.

(c) Submit documents to the department's division of healthcare services that verify the performance requirements listed in this section.

(3) The department waives the program requirements listed in subsection (2)(b) of this section if the hospital participates in a statewide bariatric surgery quality assurance program such as the surgical Clinical Outcomes Assessment Program (COAP).

(4) See WAC 388-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(5) Authorization does not guarantee payment. Authorization for bariatric surgery and bariatric surgery-related services is valid only if:

(a) The client is eligible on the date of admission and date of service; and

(b) The hospital and professional providers meets the criteria in this section and other applicable WAC to perform bariatric surgery and/or to provide bariatric surgery-related services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2301, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-2301, filed 5/20/05, effective 6/20/05.]

WAC 388-550-2400 Inpatient chronic pain management services. (1) The department pays a hospital that is specifically approved by the department to provide inpatient chronic pain management services, an all-inclusive per diem facility fee. The department pays professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had pain for at least three months and has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and

(c) A client with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs and/or alcohol for at least six months.

(3) The department:

(a) Covers inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) Pays for only one inpatient hospital stay, up to a maximum of twenty-one consecutive days, for chronic pain management training per a client's lifetime.

(c) Does not require prior authorization for chronic pain management services.

(d) Does not pay for services unrelated to the chronic pain management services that are provided during the client's inpatient stay, unless the hospital requests and receives prior authorization from the department

(4) All applicable claim payment adjustments for client responsibility, third party liability, Medicare crossover, etc., apply to the department.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2400, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2500 Inpatient hospice services. (1)

The department pays hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies must bill the department for their services using revenue codes. The department pays hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department pays hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2500, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. Acute physical medicine and rehabilitation (acute PM&R) is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation. The department requires prior authorization for acute PM&R services. (See WAC 388-550-2561 for prior authorization requirements.)

(1) An interdisciplinary team coordinates individualized acute PM&R services at a department-approved rehabilitation hospital to achieve the following for a client:

(a) Improved health and welfare; and

(b) Maximum physical, social, psychological and educational or vocational potential.

(2) The department determines and authorizes a length of stay based on:

(a) The client's acute PM&R needs; and

(b) Community standards of care for acute PM&R services.

(3) When the department's authorized acute period of rehabilitation ends, the hospital provider discharges the client to the client's residence, or to an appropriate level of care.

Therapies may continue to help the client achieve maximum potential through other department programs such as:

- (a) Home health services;
- (b) Nursing facilities;
- (c) Outpatient physical, occupational, and speech therapies; or
- (d) Neurodevelopmental centers.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2501, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2501, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2511 Acute PM&R definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the acute PM&R program. If conflicts occur, this section prevails for this subchapter.

"Accredit" (or "Accreditation") means a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

"Acute" means an intense medical episode, not longer than three months.

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with acute PM&R program requirements.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2511, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2511, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2521 Client eligibility requirements for acute PM&R services. (1) Only a client who is eligible for one of the following programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC 388-550-2501, 388-550-2511, 388-550-2531, 388-550-2541, 388-550-2551, 388-550-2561, 388-550-3381, and other rules:

- (a) Categorically needy program (CNP);
- (b) State children's health insurance program (SCHIP);
- (c) Limited casualty program - Medically needy program (LCP-MNP);
- (d) Alien emergency medical (AEM)(CNP);
- (e) Alien emergency medical (AEM)(LCP-MNP);
- (f) General assistance unemployable (GA-U - No out-of-state care); or
- (g) Alcoholism and drug addiction treatment and support act (ADATSA).

(2) If a client is enrolled in a department managed care organization (MCO) plan at the time of acute care admission, that plan pays for and coordinates acute PM&R services as appropriate.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2521, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2521, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2521, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2531 Requirements for becoming an acute PM&R provider. (1) Before August 1, 2007, only an

in-state or bordering city hospital may apply to become a department-approved acute PM&R hospital. On and after August 1, 2007 an instate, bordering city, or critical border hospital may apply to become a department-approved acute PM&R hospital. To apply, the department requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Division of Healthcare Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia, WA 98504-5506

(2) A hospital that applies to become a department-approved acute PM&R facility must provide the department with documentation that confirms the facility is all of the following:

- (a) A Medicare-certified hospital;
- (b) Accredited by the joint commission on accreditation of healthcare organizations (JCAHO);
- (c) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010;
- (d) Commission on accreditation of rehabilitation facilities (CARF) accredited as a comprehensive integrated inpatient rehabilitation program or as a pediatric family centered rehabilitation program, unless subsection (3) of this section applies;

(e) For dates of admission before July 1, 2007, contracted under the department's selective contracting program, if in a selective contracting area, unless exempted from the requirements by the department; and

(f) Operating per the standards set by DOH (excluding the certified rehabilitation registered nurse (CRRN) requirement) in either:

- (i) WAC 246-976-830, Level I trauma rehabilitation designation; or
- (ii) WAC 246-976-840, Level II trauma rehabilitation designation.

(3) A hospital not yet accredited by CARF:

(a) May apply for or be awarded a twelve-month conditional written approval by the department if the facility:

(i) Provides the department with documentation that it has started the process of obtaining full CARF accreditation; and

(ii) Is actively operating under CARF standards.

(b) Is required to obtain full CARF accreditation within twelve months of the department's conditional approval date. If this requirement is not met, the department sends a letter of notification to revoke the conditional approval.

(4) A hospital qualifies as a department-approved acute PM&R hospital when:

(a) The hospital meets all the applicable requirements in this section;

(b) The department's clinical staff has conducted a facility site visit; and

(c) The department provides written notification that the hospital qualifies to be paid for providing acute PM&R services to eligible medical assistance clients.

(5) The department-approved acute PM&R hospitals must meet the general requirements in chapter 388-502 WAC, Administration of medical programs—Providers.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2531, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2531, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2541 Quality of care—Department-approved acute PM&R hospital. (1) To ensure quality of care, the department may conduct reviews (e.g., post-pay, on-site) of any department-approved acute PM&R hospital.

(2) A provider of acute PM&R services must act on any report of substandard care or violation of the hospital's medical staff bylaws and CARF standards. The provider must have and follow written procedures that:

(a) Provide a resolution to either a complaint or grievance or both; and

(b) Comply with applicable CARF standards for adults or pediatrics as appropriate.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of healthcare organizations (JCAHO);

(c) CARF;

(d) The department; or

(e) Other agencies with review authority for the department's programs.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2541, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2541, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2561 The department's prior authorization requirements for acute PM&R services. (1) The department requires prior authorization for acute PM&R services. The acute PM&R provider of services must obtain prior authorization:

(a) Before admitting a client to the rehabilitation unit; and

(b) For an extension of stay before the client's current authorized period of stay expires.

(2) For an initial admit:

(a) A client must:

(i) Be eligible under one of the programs listed in WAC 388-550-2521, subject to the restrictions and limitations listed in that section;

(ii) Require acute PM&R services as determined in WAC 388-550-2551;

(iii) Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program; and

(iv) Be willing and capable to participate at least three hours per day, seven days per week, in acute PM&R activities.

(b) The acute PM&R provider of services must:

(i) Submit a request for prior authorization to the department's clinical consultation team by fax, electronic mail, or telephone as published in the department's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify that:

(A) Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care and/or independence;

(B) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive acute PM&R services be provided in a department-approved acute PM&R facility; and

(C) The client suffers from severe disabilities including, but not limited to, neurological and/or cognitive deficits.

(3) For an extension of stay:

(a) A client must meet the conditions listed in subsection (2)(a) of this section and have observable and significant improvement; and

(b) The acute PM&R provider of services must:

(i) Submit a request for the extension of stay to the department clinical consultation team by fax, electronic mail, or telephone as published in the department's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify the extension and include documentation that the client's condition has observably and significantly improved.

(4) If the department denies the request for an extension of stay, the client must be transferred to an appropriate lower level of care as described in WAC 388-550-2501(3).

(5) The department's clinical consultation team approves or denies authorization for acute PM&R services for initial stays or extensions of stay based on individual circumstances and the medical information received. The department notifies the client and the acute PM&R provider of a decision.

(a) If the department approves the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The allowed dates of service;

(iii) A department-assigned authorization number;

(iv) Applicable limitations to the authorized services; and

(v) The department's process to request additional services.

(b) If the department denies the request for authorization, the notification letter includes:

(i) The number of days requested;

(ii) The reason for the denial;

(iii) Alternative services available for the client; and

(iv) The client's right to request a fair hearing. (See subsection (7) of this section.)

(6) A hospital or other facility intending to transfer a client to a department-approved acute PM&R hospital, and/or a department-approved acute PM&R hospital requesting an extension of stay for a client, must:

(a) Discuss the department's authorization decision with the client and/or the client's legal representative; and

(b) Document in the client's medical record that the department's decision was discussed with the client and/or the client's legal representative.

(7) A client who does not agree with a decision regarding acute PM&R services has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, the department may request additional information from the client and the facility, or both. After the department reviews the available information, the result may be:

(a) A reversal of the initial department decision;

- (b) Resolution of the client's issue(s); or
- (c) A fair hearing conducted per chapter 388-02 WAC.

(8) The department may authorize administrative day(s) for a client who:

(a) Does not meet requirements described in subsection (3) of this section; or

(b) Is waiting for a discharge destination or a discharge plan.

(9) The department does not authorize acute PM&R services for a client who:

(a) Is deconditioned by a medical illness or by surgery; or

(b) Has loss of function primarily as a result of a psychiatric condition(s); or

(c) Has had a recent surgery and has no complicating neurological deficits. Examples of surgeries that do not qualify a client for inpatient acute PM&R services without extenuating circumstances are:

- (i) Single amputation;
- (ii) Single extremity surgery; and
- (iii) Spine surgery.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-12-039, § 388-550-2561, filed 5/30/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2561, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2565 The long-term acute care (LTAC) program—General. The long-term acute care (LTAC) program is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a department-approved LTAC hospital during the acute phase of a client's care. The department requires prior authorization for LTAC stays. See WAC 388-550-2590 for prior authorization requirements.

(1) A facility's multidisciplinary team coordinates individualized LTAC services at a department-approved LTAC hospital.

(2) The department determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in WAC 388-550-2590.

(3) When the department-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-11-129, § 388-550-2565, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2565, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2570 LTAC program definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the LTAC program.

"Level 1 services" means long-term acute care (LTAC) services provided to clients who require more than eight hours of direct skilled nursing care per day. Level 1 services include one or both of the following:

(1) Active ventilator weaning care and any specialized therapy services, such as physical, occupational, and speech therapies; or

(2) Complex medical care that may include: Care for complex draining wounds, care for central lines, multiple medications, frequent assessments and close monitoring, third degree burns that may involve grafts and/or frequent transfusions, and specialized therapy services, such as physical, occupational, and speech therapies.

"Level 2 services" means long-term acute care (LTAC) services provided to clients who require four to eight hours of direct skilled nursing care per day. Level 2 services include at least two of the following:

(1) Ventilator care for clients who are stable, dependent on a ventilator, and have complex medical needs;

(2) Care for clients who have tracheostomies, complex airway management and medical needs, and the potential for decannulation; and

(3) Specialized therapy services, such as physical, occupational, and speech therapies.

"Long-term acute care" means inpatient intensive long-term care services provided in department-approved LTAC hospitals to eligible medical assistance clients who require Level 1 or Level 2 services.

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements.

"Transportation company" means either a department-approved transportation broker or a transportation company doing business with the department.

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-11-129, § 388-550-2570, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2570, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2575 Client eligibility requirements for LTAC services. Only a client who is eligible for one of the following programs may receive LTAC services, subject to the restrictions and limitations in WAC 388-550-2565, 388-550-2570, 388-550-2580, 388-550-2585, 388-550-2590, 388-550-2595, 388-550-2596, and other rules:

- (1) Categorically needy program (CNP);
- (2) State children's health insurance program (SCHIP);
- (3) Limited casualty program - medically needy program (LCP-MNP);
- (4) Alien emergency medical (AEM)(CNP); or
- (5) Alien emergency medical (AEM)(LCP-MNP).

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-11-129, § 388-550-2575, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2575, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2580 Requirements for becoming an LTAC hospital. (1) To apply to become a department-approved LTAC hospital, the department requires a hospital to:

(a) Submit a letter of request to:

LTAC Program Manager
Division of Healthcare Services
Health and Recovery Services Administration
P.O. Box 45506
Olympia WA 98504-5506; and

(b) Include documentation that confirms the facility is:

(i) Medicare certified for LTAC;

(ii) Accredited by the joint commission on accreditation of healthcare organizations (JCAHO);

(iii) For an in-state hospital licensed as an acute care hospital by the department of health (DOH) under WAC 246-310-010;

(iv) For a hospital located out-of-state, licensed as an acute care hospital by that state; and

(v) Contracted with the department to provide LTAC services if the LTAC hospital is located outside the state of Washington.

(2) The hospital qualifies as a department-approved LTAC hospital when:

(a) The hospital meets all the requirements in this section;

(b) The department's clinical staff has conducted an on-site visit; and

(c) The department provides written notification that the hospital qualifies to be paid for providing LTAC services to eligible medical assistance clients.

(3) Department-approved LTAC hospitals must meet the general requirements in chapter 388-502 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-11-129, § 388-550-2580, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 02-14-162, § 388-550-2580, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2585 LTAC hospitals—Quality of care. (1) To ensure quality of care, the department may conduct post-pay or on-site reviews of any department-approved LTAC hospital. See WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for additional information on audits conducted by department staff.

(2) A provider of LTAC services must act on any reports of substandard care or violations of the hospital's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or grievance or both.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The joint commission on accreditation of healthcare organizations (JCAHO);

(c) The department; or

(d) Other agencies with review authority for the department's programs.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-11-129, § 388-550-2585, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 02-14-162, § 388-550-2585, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2590 Department prior authorization requirements for Level 1 and Level 2 LTAC services. (1) The department requires prior authorization for Level 1 and Level 2 LTAC inpatient stays. The prior authorization process includes all of the following:

(a) For an initial thirty-day stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC 388-550-2575;

(B) Meet the high cost outlier or high outlier status, respectively, at the transferring hospital as described in WAC 388-550-3700. Exception: If the claim is paid under a pay-

ment method other than the DRG or per diem payment method, the claim must meet the same outlier threshold described in WAC 388-550-3700.

(C) Require Level 1 or Level 2 LTAC services as defined in WAC 388-550-2570.

(ii) The LTAC provider of services must:

(A) Before admitting the client to the LTAC hospital, submit a request for prior authorization to the department's clinical consultation team by fax, electronic mail, or telephone, as published in the department's LTAC billing instructions;

(B) Include sufficient medical information to justify the requested initial stay.

(C) Receive prior authorization from the department's medical director or designee, based on clinical quality review by the department's clinical consultation team to determine the client's circumstances and the medical justification for transfer from the transferring hospital; and

(D) Meet all the requirements in WAC 388-550-2580.

(i) For extensions of stay:

(i) The client must:

(A) Be eligible under one of the programs listed in WAC 388-550-2575; and

(B) Require Level 1 or Level 2 LTAC services as defined in WAC 388-550-2570.

(ii) The LTAC provider of services must:

(A) Before the client's current authorized period of stay expires, submit a request for the extension of stay to the department's clinical consultation team by fax, electronic mail, or telephone; and

(B) Include sufficient medical information to justify the requested extension of stay.

(2) The department's clinical consultation team authorizes Level 1 or Level 2 LTAC services for initial stays or extensions of stay based on the client's circumstances and the medical justification received. A client who does not agree with a decision regarding a length of stay has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, the department may request additional information from the client and the facility, or both. After the department reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

(3) The department may authorize administrative day rate payment for a client who:

(a) Does not meet the requirements described in this section;

(b) Is waiting for placement in another hospital or other facility; or

(c) If appropriate, is waiting to be discharged to the client's residence.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-11-129, § 388-550-2590, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 02-14-162, § 388-550-2590, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2595 Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate. (1) In addition to room and board, the LTAC fixed per diem rate includes, but is not lim-

ited to, the following (see the department's LTAC billing instructions for applicable revenue codes):

- (a) Room and board - Rehabilitation;
- (b) Room and board - Intensive care;
- (c) Pharmacy - Up to and including two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;
- (d) Medical/surgical supplies and devices;
- (e) Laboratory - General;
- (f) Laboratory - Chemistry;
- (g) Laboratory - Immunology;
- (h) Laboratory - Hematology;
- (i) Laboratory - Bacteriology and microbiology;
- (j) Laboratory - Urology;
- (k) Laboratory - Other laboratory services;
- (l) Respiratory services;
- (m) Physical therapy;
- (n) Occupational therapy; and
- (o) Speech-language therapy.

(2) The department pays the LTAC hospital for services covered by the LTAC fixed per diem rate by the rate in effect at the date of admission, minus the sum of:

- (a) Client liability, whether or not collected by the provider; and
- (b) Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:
 - (i) Insurers and indemnitors;
 - (ii) Other federal or state healthcare programs;
 - (iii) Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and
 - (iv) Any other contractual or legal entitlement of the client, including, but not limited to:
 - (A) Crime victims' compensation;
 - (B) Workers' compensation;
 - (C) Individual or group insurance;
 - (D) Court-ordered dependent support arrangements; and
 - (E) The tort liability of any third party.

(3) The department may make annual rate increases to the LTAC fixed per diem rate by using a vendor rate increase. The department may rebase the LTAC fixed per diem rate periodically.

(4) When the department establishes a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the department.

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-11-129, § 388-550-2595, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 03-02-056, § 388-550-2595, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2595, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2596 Services and equipment covered by the department but not included in the LTAC fixed per diem rate. (1) The department uses the ratio of costs-to-charges (RCC) payment method to pay an LTAC hospital for the following that are not included in the LTAC fixed per diem rate:

- (a) Pharmacy - After the first two hundred dollars per day in total allowed covered charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;
- (b) Radiology services;
- (c) Nuclear medicine services;
- (d) Computerized tomographic (CT) scan;
- (e) Operating room services;
- (f) Anesthesia services;
- (g) Blood storage and processing;
- (h) Blood administration;
- (i) Other imaging services - Ultrasound;
- (j) Pulmonary function services;
- (k) Cardiology services;
- (l) Recovery room services;
- (m) EKG/ECG services;
- (n) Gastro-intestinal services;
- (o) Inpatient hemodialysis; and
- (p) Peripheral vascular laboratory services.

(2) The department uses the appropriate inpatient or outpatient payment method described in other published WAC to pay providers other than LTAC hospitals for services and equipment that are covered by the department but not included in the LTAC fixed per diem rate. The provider must bill the department directly and the department pays the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC hospital, or related to transporting a client to another facility after discharge from the LTAC hospital:

- (a) Are not covered or reimbursed through the LTAC fixed per diem rate;
- (b) Are not payable directly to the LTAC hospital;
- (c) Are subject to the provisions in chapter 388-546 WAC; and
- (d) Must be billed directly to the:
 - (i) Department by the transportation company to be reimbursed if the client required ambulance transportation; or
 - (ii) Department's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 388-546 WAC, if the client:
 - (A) Required nonemergency transportation; or
 - (B) Did not have a medical condition that required transportation in a prone or supine position.

(4) The department evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.

(5) When the department established a special client service contract to complement the core provider agreement with an out-of-state LTAC hospital for services, the contract terms take precedence over any conflicting payment program policies set in WAC by the department.

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-11-129, § 388-550-2596, filed 5/22/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-550-2596, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 03-02-056, § 388-550-2596, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2596, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2598 Critical access hospitals (CAHs).

(1) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this section:

(a) "CAH," see "critical access hospital."

(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled Medicare cost report (Form 2552-96) after the end of the CAH's HFY.

(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.

(d) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (5) of this section for how the department calculates a DWCC rate.

(e) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."

(f) "HFY" see "Hospital fiscal year."

(g) "Hospital fiscal year" means each individual hospital's Medicare cost report fiscal year.

(h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate DWCC rate, as determined by the department.

(i) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's Medicare cost report.

(2) To be paid as a CAH by the department, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the department upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.

(3) The department pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using departmental weighted costs-to-charges (DWCC) rates and a retrospective cost settlement process. The department pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care Health Options and MHD designee DWCC payment rates to be cost. Cost settlements are not performed by the department for managed care claims.

(5) The department prospectively calculates fee-for-service and managed care inpatient and outpatient DWCC rates separately for each CAH.

(a) Prior to the department's calculation of the prospective interim inpatient DWCC and outpatient DWCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the department:

(i) Within twenty working days of receiving the request from the department, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the Medicare cost report the CAH initially submits to the Medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same Medicare cost report;

(iii) At the same time that the "as filed" version of the Medicare cost report the CAH has submitted to the Medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's Medicare cost report;

(iv) At the same time that the "as filed" version of the Medicare cost report the CAH has submitted to the Medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the department provides to the CAH from the department's CAH DWCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the department, that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the department's CAH DWCC rate calculation model, but identified to the surgery cost center in the CAH's submitted Medicare cost report.)

(b) The department:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH DWCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely submit the document, the department may use the CAH DWCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH DWCC rate calculation model when the department calculates the DWCC rates. This is a standard the department follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH DWCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the Medicare cost report. (For example, a CAH reports to the department that in the department's standard radiology cost center grouping in the CAH DWCC rate calculation model, the hospital has established three cost centers in the Medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the department combines these three cost centers under the standard radiology cost center grouping. No unbundling of the standard cost center grouping is allowed.)

- (c) The department:
- (i) Obtains from its Medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:
 - (A) Medical assistance program codes;
 - (B) Inpatient and outpatient hospital claim types;
 - (C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);
 - (D) Claim allowed charges, third party liability, client paid amounts, and department paid amounts; and
 - (E) Units of service.
 - (ii) Obtains Level III trauma payment data from the department of health (DOH).
 - (iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the Medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.
 - (iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:
 - (A) Medical assistance program codes;
 - (B) Inpatient and outpatient hospital claim types;
 - (C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and
 - (D) Claim allowed charges.
 - (v) Separates the inpatient claims data and outpatient hospital claims data;
 - (vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" Medicare cost report the CAH initially submits to the department.
 - (vii) Uses the claims classifications and cost center combinations as defined in the department's CAH DWCC rate calculation model;
 - (viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;
 - (ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;
 - (x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);
 - (xi) Determines the departmental-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;
 - (xii) Sums all:
 - (A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.
 - (B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.
 - (xiii) Sums all:
 - (A) Departmental-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.
 - (B) Departmental-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.
 - (xiv) Multiplies each hospital's total departmental-weighted costs from (c)(xiii) of this subsection by the centers for Medicare and Medicaid services (CMS) Medicare market basket inflation rate to update costs from the HFY to the rate setting period. The Medicare market basket inflation rate is published and updated by CMS periodically;
 - (xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is not submitted timely by the hospital (see (a)(i) of this subsection), the department will apply a reasonable alternative factor; and
 - (xvi) Determines:
 - (A) The inpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.
 - (B) The outpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.
- (6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective DWCC rates for inpatient and outpatient hospital claims for:
- (a) Fee-for-service clients is:
 - (i) The hospital's most recent "as filed" Medicare cost report; and
 - (ii) The appropriate MMIS summary claims data for that HFY.
 - (b) MCO clients is:
 - (i) The hospital's most recent "as filed" Medicare cost report; and
 - (ii) The appropriate managed care encounter data for that HFY.
- (7) For a newly licensed hospital that is also a CAH, the department uses the current statewide average DWCC rates for the initial prospective DWCC rates.
- (8) For a CAH that comes under new ownership, the department uses the prior owner's DWCC rates until:
- (a) The new owner submits its first "as filed" Medicare cost report to the Medicare fiscal intermediary, and at the same time to the department, the documents identified in (5)(a)(i) through (a)(iv) of this section; and
 - (b) The department has calculated new DWCC rates based on the new owner's "as filed" Medicare cost report and other timely submitted documents.
- (9) In addition to the prospective managed care inpatient and outpatient DWCC rates, the department:
- (a) Incorporates the DWCC rates into the calculations for the department's MCO capitated premium that will be paid to the MCO plan; and
 - (b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient DWCC rates applicable to managed care claims. For purposes of this section, the department considers the DWCC rates used to pay CAHs for care given to clients enrolled in an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the department uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" Medicare cost report data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the department:

(a) Compares actual department total interim CAH payments to the departmental-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, department claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The department recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department uses the hospital's "final settled" Medicare cost report instead of the initial "as filed" Medicare cost report for the HFY being cost settled. The "final settled" Medicare cost report received from the Medicare fiscal intermediary must be submitted by the CAH to the department by the sixtieth day of the hospital's receipt of that Medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for department programs.

(14) The department pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than DWCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the department uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The department may conduct a post pay or on-site review of any CAH.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-054, § 388-550-2598, filed 6/28/07, effective 8/1/07; 07-03-077, § 388-550-2598, filed 1/17/07, effective 2/17/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.5225, 06-04-089, § 388-550-2598, filed 1/31/06, effective 3/3/06; 05-01-026, § 388-550-2598, filed 12/3/04, effective 1/3/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.5225, and HB 1162, 2001 2nd sp.s. c 2. 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]

WAC 388-550-2600 Inpatient psychiatric services.

(1) The department, on behalf of the mental health division (MHD), regional support networks (RSNs) and prepaid inpatient health plans (PIHPs), pays for covered inpatient psychiatric services for a voluntary or involuntary inpatient psychiatric admission of an eligible medical assistance client, subject to the limitation and restrictions in this section and other published rules.

(2) The following definitions and abbreviations and those found in WAC 388-550-0005 and 388-550-1050 apply to this section (where there is any discrepancy, this section prevails):

(a) "Authorization number" refers to a number that is required on a claim in order for a provider to be paid for providing psychiatric inpatient services to a medical assistance client. An authorization number:

(i) Is assigned when the certification process and prior authorization process has occurred;

(ii) Identifies a specific request for the provision of psychiatric inpatient services to a medical assistance client;

(iii) Verifies when prior or retrospective authorization has occurred;

(iv) Will not be rescinded once assigned; and

(v) Does not guarantee payment.

(b) "Certification" means a clinical determination by an MHD designee that a client's need for a voluntary or involuntary inpatient psychiatric admission, length of stay extension, or transfer has been reviewed and, based on the information provided, meets the requirements for medical necessity for inpatient psychiatric care. The certification process occurs concurrently with the prior authorization process.

(c) "IMD" See "institution for mental diseases."

(d) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The MHD designates whether a facility meets the definition for an IMD.

(e) "Involuntary admission" refer to chapters 71.05 and 71.34 RCW.

(f) "Mental health division (MHD)" is the unit within the department of social and health services (DSHS) authorized to contract for and monitor delivery of mental health programs. MHD is also known as the state mental health authority.

(g) "Mental health division designee" or "MHD designee" means a professional contact person authorized by

MHD, who operates under the direction of a regional support network (RSN) or a prepaid inpatient health plan (PIHP).

(h) "PIHP" see "prepaid inpatient health plan."

(i) "Prepaid inpatient health plan (PIHP)" see WAC 388-865-0300.

(j) "Prior authorization" means an administrative process by which hospital providers must obtain an MHD designee's for a client's inpatient psychiatric admission, length of stay extension, or transfer. The prior authorization process occurs concurrently with the certification process.

(k) "Regional support network (RSN)" see WAC 388-865-0200.

(l) "Retrospective authorization" means a process by which hospital providers and hospital unit providers must obtain an MHD designee's certification after services have been initiated for a medical assistance client. Retrospective authorization can be prior to discharge or after discharge. This process is allowed only when circumstances beyond the control of the hospital or hospital unit provider prevented a prior authorization request, or when the client has been determined to be eligible for medical assistance after discharge.

(m) "RSN" see "regional support network."

(n) "Voluntary admission" refer to chapters 71.05 and 71.34 RCW.

(3) The following department of health (DOH)-licensed hospitals and hospital units are eligible to be paid for providing inpatient psychiatric services to eligible medical assistance clients, subject to the limitations listed:

(a) Medicare-certified distinct part psychiatric units;

(b) State-designated pediatric psychiatric units;

(c) Hospitals that provide active psychiatric treatment outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician according to WAC 246-322-170; and

(d) Free-standing psychiatric hospitals approved as an institution for mental diseases (IMD).

(4) An MHD designee has the authority to approve or deny a request for initial certification for a client's voluntary inpatient psychiatric admission and will respond to the hospital's or hospital unit's request for initial certification within two hours of the request. An MHD designee's certification and authorization, or a denial, will be provided within twelve hours of the request. Authorization must be requested prior to admission. If the hospital chooses to admit the client without prior authorization due to staff shortages, the request for an initial certification must be submitted the same calendar day (which begins at midnight) as the admission. In this case, the hospital assumes the risk for denial as the MHD designee may or may not authorize the care for that day.

(5) To be paid for a voluntary inpatient psychiatric admission:

(a) The hospital provider or hospital unit provider must meet the applicable general conditions of payment criteria in WAC 388-502-0100; and

(b) The voluntary inpatient psychiatric admission must meet the following:

(i) For a client eligible for medical assistance, the admission to voluntary inpatient psychiatric care must:

(A) Be medically necessary as defined in WAC 388-500-0005;

(B) Be ordered by an agent of the hospital who has the clinical or administrative authority to approve an admission;

(C) Be prior authorized and meet certification and prior authorization requirements as defined in subsection (2) of this section. See subsection (8) of this section for a voluntary inpatient psychiatric admission that was not prior authorized and requires retrospective authorization by the client's MHD designee; and

(D) Be verified by receipt of a certification form dated and signed by an MHD designee (see subsection (2) of this section). The form must document at least the following:

(I) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(II) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170);

(III) The inpatient services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning;

(IV) The client has been diagnosed as having an emotional or behavioral disorder, or both, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; and

(V) The client's principle diagnosis must be an MHD covered diagnosis.

(ii) For a client eligible for both Medicare and a medical assistance program, the department pays secondary to Medicare.

(iii) For a client eligible for both Medicare and a medical assistance program and who has not exhausted Medicare lifetime benefits, the hospital provider or hospital unit provider must notify the MHD designee of the client's admission if the dual eligibility status is known. The admission:

(A) Does not require prior authorization by an MHD designee; and

(B) Must be in accordance with Medicare standards.

(iv) For a client eligible for both Medicare and a medical assistance program who has exhausted Medicare lifetime benefits, the admission must have prior authorization by a MHD designee.

(v) When a liable third party is identified (other than Medicare) for a client eligible for a medical assistance program, the hospital provider or hospital unit provider must obtain a MHD designee's authorization for the admission.

(6) To be paid for an involuntary inpatient psychiatric admission:

(a) The involuntary inpatient psychiatric admission must be in accordance with the admission criteria specified in chapters 71.05 and 71.34 RCW; and

(b) The hospital provider or hospital unit provider:

(i) Must be certified by the MHD in accordance with chapter 388-865 WAC;

(ii) Must meet the applicable general conditions of payment criteria in WAC 388-502-0100; and

(iii) When submitting a claim, must include a completed and signed copy of an Initial Certification Authorization form Admission to Inpatient Psychiatric Care form, or an Extension Certification Authorization for Continued Inpatient Psychiatric Care form.

(7) To be paid for providing continued inpatient psychiatric services to a medical assistance client who has already

been admitted, the hospital provider or hospital unit provider must request from an MHD designee within the time frames specified, certification and authorization as defined in subsection (2) of this section for any of the following circumstances:

(a) If the client converts from involuntary (legal) status to voluntary status, or from voluntary to involuntary (legal) status as described in chapter 71.05 or 71.34 RCW, the hospital provider or hospital unit provider must notify the MHD designee within twenty-four hours of the change. Changes in legal status may result in issuance of a new certification and authorization. Any previously authorized days under the previous legal status that are past the date of the change in legal status are not billable;

(b) If an application is made for determination of a patient's medical assistance eligibility, the request for certification and prior authorization must be submitted within twenty-four hours of the application;

(c) If there is a change in the client's principal ICD9-CM diagnosis to an MHD covered diagnosis, the request for certification and prior authorization must be submitted within twenty-four hours of the change;

(d) If there is a request for a length of stay extension for the client, the request for certification and prior authorization must be submitted prior to the end of the initial authorized days of services (see subsections (11) and (12) of this section for payment methodology and payment limitations); and

(e) If the client is to be transferred from one community hospital to another community hospital for continued inpatient psychiatric care, the request for certification and prior authorization must be submitted prior to the transfer.

(f) If a client who has been authorized for inpatient care by the MHD designee has been discharged or left against medical advice prior to the expiration of previously authorized days, a hospital provider or hospital unit provider must notify the MHD designee within twenty-four hours of discharge. Any previously authorized days past the date the client was discharged or left the hospital are not billable.

(8) An MHD designee has the authority to approve or deny a request for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer when the hospital provider or hospital unit provider did not notify the MHD designee within the notification timeframes stated in this section. For a retrospective certification request prior to discharge, the MHD designee responds to the hospital or hospital unit within two hours of the request, and provides certification and authorization or a denial within twelve hours of the request. For retrospective certification requests after the discharge, the hospital or hospital unit must submit all the required clinical information to the MHD designee within thirty days of discharge. The MHD designee provides a response within thirty days of the receipt of the required clinical documentation. All retrospective certifications must meet the requirements in this section. An authorization or denial is based on the client's condition and the services provided at the time of admission and over the course of the hospital stay, until the date of notification or discharge, as applicable.

(9) To be paid for a psychiatric inpatient admission of an eligible medical assistance client, the hospital provider or hospital unit provider must submit on the claim form the

authorization (see subsection (2)(a) for definition of prior authorization and retrospective authorization).

(10) The department uses the payment methods described in WAC 388-550-2650 through 388-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to medical assistance clients, unless otherwise specified in this section.

(11) Covered days for a voluntary psychiatric admission are determined by a MHD designee utilizing MHD approved utilization review criteria.

(12) The number of initial days authorized for an involuntary psychiatric admission is limited to twenty days from date of detention. The hospital provider or hospital unit provider must submit the Extension Certification Authorization for Continued Inpatient Psychiatric Care form twenty-four hours prior to the expiration of the previously authorized days. Extension requests may not be denied for a person detained under ITA unless a less restrictive alternative is identified by the MHD designee and approved by the court. Extension requests may not be denied for youths detained under ITA who have been referred to the children's long-term inpatient program unless a less restrictive alternative is identified by the MHD designee and approved by the court.

(13) The department pays the administrative day rate for any authorized days that meet the administrative day definition in WAC 388-550-1050, and when all of the following conditions are met:

(a) The client's legal status is voluntary admission;
 (b) The client's condition is no longer medically necessary;
 (c) The client's condition no longer meets the intensity of service criteria;

(d) Less restrictive alternative treatments are not available, posing barrier to the client's safe discharge; and

(e) The hospital or hospital unit and the MHD designee mutually agree that the administrative day is appropriate.

(14) The hospital provider or hospital unit provider will use the MHD approved due process for conflict resolution regarding medical necessity determinations provided by the MHD designee.

(15) In order for an MHD designee to implement and participate in a medical assistance client's plan of care, the hospital provider or hospital unit provider must provide any clinical and cost of care information to the MHD designee upon request. This requirement applies to all medical assistance clients admitted for:

(a) Voluntary inpatient psychiatric services; and
 (b) Involuntary inpatient psychiatric services, regardless of payment source.

(16) If the number of days billed exceeds the number of days authorized by the MHD designee for any claims paid, the department will recover any unauthorized days paid.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-053, § 388-550-2600, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2650 Base community psychiatric hospitalization payment method for Medicaid and SCHIP clients and non-Medicaid and non-SCHIP clients.
 (1) Effective for dates of admission from July 1, 2005

through June 30, 2007, and in accordance with legislative directive, the department implemented two separate base community psychiatric hospitalization payment rates, one for Medicaid and SCHIP clients and one for non-Medicaid and non-SCHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for Medicaid and SCHIP clients and non-Medicaid and non-SCHIP clients is no longer used. (For the purpose of this section, a "non-Medicaid or non-SCHIP client" is defined as a client eligible under the general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered program, as determined by the department.)

(a) The Medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to Medicaid and SCHIP covered patients, paid to hospitals that accept commitments under the involuntary treatment act (ITA).

(b) The non-Medicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC 388-500-0005. In addition, the department considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The department does not consider detoxification to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate mental health division (MHD) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 388-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a MHD designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC 388-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act patient claim information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the county involuntary treatment office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and department-covered services.

(6) The Medicaid base community psychiatric hospitalization payment rate applies only to a Medicaid or SCHIP client admitted to a nonstate-owned free-standing psychiatric hospital located in Washington state.

(7) The non-Medicaid base community psychiatric hospitalization payment rate applies only to a non-Medicaid or SCHIP client admitted to a hospital:

(a) Designated by the department as an ITA-certified hospital; or

(b) That has a department-certified ITA bed that was used to provide ITA services at the time of the non-Medicaid or non-SCHIP admission.

(8) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the department pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For Medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the department-specific nondiagnosis related group (DRG) payment method.

(ii) For non-Medicaid and non-SCHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-Medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For Medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system.

(ii) For non-Medicaid and SCHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-Medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A nonstate-owned free-standing psychiatric hospital as follows:

(i) For Medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

- (A) The ratio of costs-to-charges (RCC) allowable; or
- (B) The Medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For non-Medicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid the same as for Medicaid and SCHIP clients, except the base community inpatient psychiatric hospital payment rate is the non-Medicaid rate, and the RCC allowable is the state-administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For Medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650.

(ii) For non-Medicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650 in conjunction with the non-Medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For Medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

(ii) For non-Medicaid [and] non-SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-053, § 388-550-2650, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518, § 204, Part II. 07-06-043, § 388-550-2650, filed 3/1/07, effective 4/1/07.]

WAC 388-550-2800 Payment methods and limits—Inpatient hospital services for Medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for Medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

| Payment method used for Medicaid inpatient hospital claims | Applicable providers/services | Process to adjust for third-party liability insurance and any other client responsibility |
|---|---|--|
| Diagnosis related group (DRG) negotiated conversion factor | Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government | Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed [amount], minus the third-party payment amount and any client responsibility amount. Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed [amount], minus the third-party payment amount and any client responsibility amount. The allowable minus the third-party payment amount and any client responsibility amount. |
| DRG cost-based conversion factor | Hospitals not participating in or exempt from the Medicaid hospital selective contracting program | Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed [amount], minus the third-party payment amount and any client responsibility amount. The allowable minus the third-party payment amount and any client responsibility amount. |
| Ratio of costs-to-charges (RCC) | Some services exempt from DRG payment methods | The allowable minus the third-party payment amount and any client responsibility amount. |
| Costs-to-charges rate with a "hold harmless" settlement provision | Hospitals eligible to be paid through the certified public expenditure (CPE) payment program | For the "hold harmless" settlement, the lesser of the billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount. The payment made is the federal share only. |
| Single case rate | Hospitals eligible to provide bariatric surgery to medical assistance clients | Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the single case rate allowed amount minus the third-party payment amount and any client responsibility amount. |

| Payment method used for Medicaid inpatient hospital claims | Applicable providers/services | Process to adjust for third-party liability insurance and any other client responsibility |
|--|--|---|
| Fixed per diem rate | Long-term acute care (LTAC) hospitals | Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the per diem allowed amount minus the third-party payment amount and any client responsibility amount. |
| Per diem rate | Some providers/services exempt from the DRG payment methods | Per diem allowed amount, and for some services a high outlier amount, minus the third-party payer amount and any client responsibility amount. |
| Cost settlement | DOH-approved critical access hospitals (CAHs) | The allowed amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount. |
| Medicaid base community psychiatric hospitalization rate | Nonstate-owned free-standing psychiatric hospitals located in Washington state | Paid according to applicable payment method in WAC 388-550-2650 for Medicaid and SCHIP clients, minus the third-party payment amount and any client responsibility amount. |

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs. The department's policy for payment on state-administered program claims that involve third-party liability (TPL) and/or client responsibility payments on claims is the same policy indicated in the table in subsection (1) in this section. However, to determine the department's payment on the claim, state-administered program rates, not Medicaid or SCHIP rates, apply when comparing the lesser of either the billed amount minus the third-party payment and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount.

(2) The department's annual aggregate Medicaid and SCHIP payments to each hospital for inpatient hospital services provided to Medicaid and SCHIP clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR Sec. 447.271). The department recoups annual aggregate Medicaid and SCHIP payments that are in excess of the usual and customary charges.

(3) The department's annual aggregate payments for inpatient hospital services, including state-operated hospitals, will not exceed the estimated amounts that the department would have paid using Medicare payment principles.

(4) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the department's medical assistance program must annually submit to the department:

(a) A copy of the hospital's CMS Medicare cost report (form 2552-96) that is the official "as filed" cost report submitted to the Medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 388-550-4900 for the requirement for a hospital to qualify for a DSH payment.

(6) Reports referred to in subsection (5) of this section must be completed according to:

- (a) Medicare's cost reporting requirements;
- (b) The provisions of this chapter; and
- (c) Instructions issued by the department.

(7) The department requires hospitals to follow generally accepted accounting principles.

(8) Participating hospitals must permit the department to conduct periodic audits of their financial records, statistical records, and any other records as determined by the department.

(9) The department limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(10) For a client's hospital stay that involves both regional support network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

(11) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-018, § 388-550-2800, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518, § 204, Part II. 07-06-043, § 388-550-2800, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-2800, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 74.09.500, 04-19-113, § 388-550-2800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 02-21-019, § 388-550-2800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-2800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652, 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-2800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems inefficacious changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the department; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of such a hospital, that meets the definition in RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act; or

(c) Be an out-of-state hospital that meets the conditions in WAC 388-550-6700.

(2) The department does not pay:

(a) A hospital or distinct unit for inpatient care and/or services provided to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) A hospital or distinct unit for care and/or services provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) A hospital or distinct unit for ancillary services in addition to the:

(i) Diagnosis related group (DRG) payment, or per case rate payment on claims with dates of admission before August 1, 2007; or

(ii) DRG payment, per diem payment, or per case rate payment on claims with dates of admission on and after August 1, 2007.

(d) For additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the department or mental health division (MHD) designee (see WAC 388-550-2600), as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not requested and/or received approval for an extended length of stay (LOS) from the department or MHD designee as specified in WAC 388-550-4300(6). The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700, to evaluate an extended LOS. A MHD designee may also perform those utilization reviews to evaluate an extended LOS.

(e) For dates of admission before August 1, 2007, for elective or nonemergency inpatient services provided in a nonparticipating hospital. A nonparticipating hospital is defined in WAC 388-550-1050. See also WAC 388-550-4600.

(f) For inpatient hospital services when the department determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The department may perform a retrospective utilization review as described in WAC 388-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(g) For two separate inpatient hospitalizations if a client is readmitted to the same or different hospital or distinct unit within seven calendar days of discharge, unless the readmission is due to conditions unrelated to the previous admission.

The department:

(i) May perform a retrospective utilization review as described in WAC 388-550-1700 to determine the appropriate payment for the readmission.

(ii) Determines if the combined hospital stay for the admission qualifies to be paid as an outlier. See WAC 388-550-3700 for DRG high-cost outliers and per diem high outliers for dates of admission on and after August 1, 2007.

(h) For a client's day(s) of absence from the hospital or distinct unit.

(i) For an inappropriate or nonemergency transfer of a client from one acute care hospital or distinct unit to another. The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700 to determine if the admission to the second hospital or distinct unit qualifies for payment. See also WAC 388-550-3600 for hospital transfers.

(3) An interim billed inpatient hospital claim submitted for a client's continuous inpatient hospitalization of at least sixty calendar days, is considered for payment by the department only when the following occurs (this does not apply to interim billed hospital claims for which the department is not the primary payer (see (b) of this subsection), or to inpatient psychiatric admissions:

(a) Each interim billed hospital claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged prior to the next sixty calendar day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the department is not the primary payer, the department pays an interim billed hospital claim when the criteria in (a) of this subsection are met and:

(i) After sixty calendar days from the date the department becomes the primary payer; or

(ii) The date a client eligible for both Medicare and Medicaid has exhausted the Medicare lifetime reserve days for inpatient hospital care.

(4) A hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less is considered for payment by the department upon the client's discharge from the hospital or distinct unit. The department considers a client discharged from the hospital or distinct unit if one of the following occurs. The client:

(a) Obtains a formal release issued by the hospital or distinct unit;

(b) Dies in the hospital or distinct unit;

(c) Transfers from the hospital or distinct unit as an acute care transfer; or

(d) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility.

(5) To be eligible for payment, a hospital or distinct unit must bill an inpatient hospital claim:

(a) In accordance with the current national uniform billing data element specifications:

- (i) Developed by the national uniform billing committee;
- (ii) Approved and/or modified by the Washington state payer group or the department; and
- (iii) In effect on the date of the client's admission.

(b) In accordance with the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) In accordance with the department's current published billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the department considers and pays an initial interim billed hospital claim and/or subsequent interim billed hospital claims; and

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (i.e., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

- (i) All inpatient hospital services provided; and
- (ii) All applicable diagnosis codes and procedure codes.

(6) The department allows the semiprivate room rate for a client's room charges, even if a hospital bills the private room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by C.F.R. §447.271.

(7) For inpatient hospital claims, the department allows hospitals an all-inclusive administrative date rate, beginning on the client's admission date, for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(8) The department pays for observation services according to WAC 388-550-3000 (2)(b), 388-550-6000 (4)(c) and 388-550-7200 (2)(e) and other applicable rules.

(9) The department determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include, but are not limited to, any client responsibility, any third party liability amount, including Medicare part A and part B, and any other adjustments as determined by the department.

(10) The department reduces payment rates to hospitals and distinct units for services provided to clients eligible under state-administered programs according to the hospital equivalency factor and/or ratable, or other department policy, as provided in WAC 388-550-4800.

(11) All hospital providers must present final charges to the department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[Statutory Authority: RCW 74.08.090 and 74.09.500, 07-14-055, § 388-550-2900, filed 6/28/07, effective 8/1/07; 04-20-058, § 388-550-2900, filed

10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-2900, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 Payment method—DRG. (1) The department uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not limited to:

(a) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's conversion factor. The total allowed amount also includes any high outlier amount calculated for claims. See WAC 388-550-3450 and 388-550-4600(4).

(5) The department's DRG payment to a hospital may be adjusted when one or more of the following occur:

(a) For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007, a claim qualifies as a DRG high outlier (see WAC 388-550-3700);

(b) A client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit (see WAC 388-550-3600);

(c) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay;

(d) A client has third party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B Medicare and Medicare has made a payment for the Part B hospital charges; or

(f) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment. Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high-cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.

(6) The department does not pay for a client's day(s) of absence from the hospital.

(7) The department pays an interim billed hospital claim or covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(8) The department applies all applicable claim payment adjustments for client responsibility, third party liability, Medicare, etc., to the payment.

[Statutory Authority: RCW 74.08.090 and 74.09.500, 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04-050, 74.08.090, 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3010 Payment method—Per diem payment. (1) Effective for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay some covered inpatient hospital services as specified in this section and WAC 388-550-4300, 388-550-4400, and 388-550-3460. The per diem payment method for long term acute care (LTAC), administrative day, and swing bed is effective for dates of admission before, and on and after, August 1, 2007.

(2) The department uses the all-patient diagnosis related group (AP-DRG) grouper software to assign a DRG classification to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG grouper software to use and updates the grouper version. This update is normally completed once every three years during inpatient payment system rebasing.

(3) A per diem payment includes, but is not limited to:

(a) A hospital covered service(s) provided to a client during the client's inpatient hospital stay.

(b) An outpatient hospital covered service(s), including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department has established an average length of stay (ALOS) for each DRG classification during the rebasing process. The DRG ALOS is used as a benchmark to authorize and pay inpatient hospital stays that are exempt from the DRG payment method. See WAC 388-550-4300(6).

(5) The department's per diem payments to hospitals may be adjusted when one or more of the following occur:

(a) A claim qualifies as a per diem high outlier claim (see WAC 388-550-3700). The outlier provision does not include a claim grouped to a DRG classification in a specialty service category. The specialty services categories include psychiatric, rehabilitation, detoxification, and CUP program services. Long term acute care (LTAC), administrative days and swing bed days do not qualify for high outlier payment;

(b) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay;

(c) A client has third party liability coverage at the time of admission to the hospital or distinct unit;

(d) A client is eligible for Medicare, and Medicare has made a payment for the hospital charges; or

(e) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital or a different hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which, if any, inpatient hospital stay(s) qualify for payment. An outlier payment may be made if the department determines the claim for the combined hospital stays qualifies as a high outlier. (See WAC 388-550-3700 for high outliers.)

(6) The department does not pay for a client's day(s) of absence from the hospital.

(7) The department pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(8) The department applies all applicable claim payment adjustments for client responsibility, third party liability, Medicare, etc., to the payment.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518, 07-14-051, § 388-550-3010, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3020 Payment method—Bariatric surgery—Per case payment. (1) The department pays designated department-approved hospitals for prior authorized bariatric surgery when the criteria in WAC 388-550-2301 are met. Claims grouped to a DRG classification in a bariatric

surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) do not qualify for outlier payments.

(2) For dates of admission before and on and after August 1, 2007, the department pays for claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) using a per case rate. See WAC 388-550-3470.

(3) The department applies all applicable claim payment adjustments for client responsibility, third party liability, Medicare, etc., to the payment.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3020, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3100 Calculating DRG relative weights. (1) This section describes how the department calculates Washington diagnostic-related group (DRG) relative weights. The department:

(a) Classifies the Washington hospital admissions data using the all-patient diagnosis related group (AP-DRG).

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes a single set of Medicaid-specific relative weights from Washington hospital admissions data. For dates of admission before August 1, 2007, the relative weights are based on claim charges. The department identifies these relative weights as stable or unstable.

(d) Tests the stability of the relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. The department accepts as stable and adopts those relative weights that pass the reasonable statistical test.

(e) For dates of admission before August 1, 2007, may compare the Medicaid-specific relative weights to non-Medicaid relative weights. The department:

(i) May combine the Medicaid-specific relative weights with the non-Medicaid relative weights if the non-Medicaid relative weights are statistically comparable to the Medicaid-specific weights; or

(ii) Uses only the Medicaid-specific relative weights if the non-Medicaid relative weights are not statistically comparable to the Medicaid-specific relative weights.

(f) For dates of admission before August 1, 2007, uses the ratio of costs-to-charges (RCC) payment method to pay for hospital stays that have unstable DRG relative weights.

(2) When using ratios with a DRG relative weight as base, the department adjusts all stable relative weights so that the average weight of the case mix population equals 1.0.

(3) For dates of admission on and after August 1, 2007, the department:

(a) Bases the relative weights on the estimated wage adjusted cost of the claims in each stable DRG classification. The operating and capital component costs were used for this process. To calculate relative weights, the department divides the average cost per discharge for each stable AP-DRG classification by the average cost per discharge for all stable AP-DRG classifications combined. For purposes of these calculations, the department uses the two most current years of

Medicaid inpatient hospital paid claims data available at the time of relative weight calibration.

(i) The department uses a combination of Medicaid fee-for-service and healthy options (HO) managed care organization (MCO) data from the two most current years of fully adjudicated paid claims data available at the time of relative weight calibration.

(ii) The department removes:

(A) Claims that represent statistical outliers from the dataset prior to calculating relative weights, based on the assumption that these claims are likely to be paid under an alternative outlier payment methodology. The department identifies statistical outliers as those claims with estimated costs that exceed three standard deviations of the mean cost of all claims in each AP-DRG classification;

(B) Claims to be paid by alternative methods, including psychiatric, rehabilitation, detoxification, CUP woman program, bariatric surgery cases, and organ transplant claims;

(C) Transfer-out claims;

(D) Same day discharges;

(E) Claims that were either ungroupable or had invalid diagnosis for AP-DRG classification purposes; and

(F) Claims related to state-administered programs where the payment calculations are based on reduced state-administered program payment rates.

(b) Uses the term "unstable" generically to describe an AP-DRG classification that has fewer than ten occurrences, or that is unstable based on the statistical stability test indicated below. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the populations's estimated standard deviation.

The formula is:

$N = (Z^2 * S^2) / R^2$, where

• The Z statistic for 90 percent confidence is 1.64;

• S = the standard deviation for the AP-DRG classification; and

• R = acceptable error range, per sampling unit.

(c) Uses:

(i) The per diem payment method to pay for hospital stays that group to an unstable DRG relative weight, some long term acute care (LTAC) services, and other specialty service and low volume services groups identified in WAC 388-550-3460.

(ii) One of the other non-DRG payment methods (e.g., RCC, per case rate, etc.) to pay for claims paid using other non-DRG payment methods (e.g., some transplants, the high outlier portion of high outlier claims, non-per diem portion of LTAC claims, bariatric surgery, etc.).

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.04.050, 04-13-048, § 388-550-3100, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3150 Base period costs and claims data. (1) The department sets a hospital's cost-based conver-

sion factor for dates of admission before August 1, 2007, using base period cost data from its Medicare cost report (Form CMS 2552) for its fiscal year corresponding with the base period.

(2) The department may use in rate-setting, "as filed" base period cost data, or "final settled" Medicare cost report base period cost data that have been desk reviewed and/or field audited by the Medicare intermediary.

(3) The department, to the extent feasible, factors out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600 before calculating the hospital's conversion factor.

(4) For dates of admission before August 1, 2007, the department uses the figures for total costs, capital costs, and direct medical education costs from a hospital's Medicare cost report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize Medicaid claims.

(5) For dates of admission before August 1, 2007, the department uses nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

- (a) Routine;
- (b) Intensive care;
- (c) Intensive care-psychiatric;
- (d) Coronary care;
- (e) Nursery;
- (f) Neonatal intensive care unit;
- (g) Alcohol/substance abuse;
- (h) Psychiatric; and
- (i) Oncology.

(6) For dates of admission before August 1, 2007, the department uses twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

- (a) Operating room;
- (b) Recovery room;
- (c) Delivery/labor room;
- (d) Anesthesiology;
- (e) Radiology-diagnostic;
- (f) Radiology-therapeutic;
- (g) Radioisotope;
- (h) Laboratory;
- (i) Blood storage;
- (j) Intravenous therapy;
- (k) Respiratory therapy;
- (l) Physical therapy;
- (m) Occupational therapy;
- (n) Speech pathology;
- (o) Electrocardiography;
- (p) Electroencephalography;
- (q) Medical supplies;
- (r) Drugs;
- (s) Renal dialysis;
- (t) Ancillary oncology;
- (u) Cardiology;
- (v) Ambulatory surgery;
- (w) Computerized tomography scan/magnetic resonance imaging;
- (x) Clinic;

- (y) Emergency;
- (z) Ultrasound;
- (aa) Neonatal intensive care unit transportation;
- (bb) Gastrointestinal laboratory; and
- (cc) Miscellaneous.

(7) The department shall:

(a) Extracts from the Medicaid management information system all Medicaid and SCHIP paid claims data for each hospital's base year;

(b) Assigns line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Uses the cost center categories to apportion Medicaid and SCHIP costs.

(8) For dates of admission on and after August 1, 2007, the department rebased the hospital inpatient payment system and used claim and estimated cost data to estimate costs for the system development.

(a) Claim data used for rebasing process. The department uses the following claim data resources considered the most complete and available at the time the system is developed for the rebase:

(i) From the department's Medicaid management information system (MMIS) database, two years of fee-for-service paid claim data, excluding claims related to state programs and paid at the Title XIX reduced rates;

(ii) From the comprehensive hospital abstract reporting system (CHARS) dataset that is maintained by the department of health (DOH), two years of sample claims representing healthy options (HO) services that are identified from the CHARS dataset based on the Medicaid HO eligibility data files; and

(iii) From the healthcare cost report information system (HCRIS) that is maintained by the centers for Medicare and Medicaid (CMS), the hospital's most current Medicare cost report data. If the hospital's Medicare cost report from the HCRIS system is not available, the department uses the Medicare cost report provided by the hospital.

(b) Claim data used to estimate costs. The department uses:

(i) The fee-for-service and HO claims for two fiscal years to calculate diagnosis related group (DRG) relative weights.

(ii) The fee-for-service and HO claims for the most current single fiscal year to calculate conversion factors, per diem rates, and per case rates.

(iii) The payments from fee-for-service only claims for a single year to model the fiscal impacts to the department and individual hospitals that result from the implementation of the payment methodology.

(c) Estimated costs of claims. The department:

(i) Identifies the operating (routine and ancillary), capital (routine and ancillary), and direct medical education (routine and ancillary) cost components from different worksheets from the hospital's Medicare cost report;

(ii) Estimates costs for each separate component identified in (c)(i) of this subsection for each fee-for-service and HO claim in the dataset by:

(A) Calculating the operating, capital, and direct medical education routine costs for each fee-for-service and HO claim by multiplying the average hospital cost per day reported in

the Medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service.

(B) Calculating the operating, capital, and direct medical education ancillary costs for each fee-for-service and HO claim by multiplying the ratio of costs-to-charges (RCC) reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, clinic) by the allowed charges reported at the claim line level by type of service.

(d) Routine and ancillary cost components. For purposes of estimating costs consistently for all hospitals' claims, the department uses standard routine and ancillary cost components. The standard cost components used for estimating costs of claims are:

(i) Routine cost components:

- (A) Routine care;
- (B) Intensive care;
- (C) Intensive care-psychiatric;
- (D) Coronary care;
- (E) Nursery;
- (F) Neonatal ICU;
- (G) Alcohol/Substance abuse;
- (H) Psychiatric;
- (I) Oncology; and
- (J) Rehabilitation.

(ii) Ancillary cost components:

- (A) Operating room;
- (B) Recovery room;
- (C) Deliver/labor room;
- (D) Anesthesiology;
- (E) Radio, diagnostic;
- (F) Radio, therapeutic;
- (G) Radioisotope;
- (H) Laboratory;
- (I) Blood administration;
- (J) Intravenous therapy;
- (K) Respiratory therapy;
- (L) Physical therapy;
- (M) Occupational therapy;
- (N) Speech pathology;
- (O) Electrocardiography;
- (P) Electroencephalography;
- (Q) Medical supplies;
- (R) Drugs;
- (S) Renal dialysis/home dialysis;
- (T) Ancillary oncology;
- (U) Cardiology;
- (V) Ambulatory surgery;
- (W) CT scan/MRI;
- (X) Clinic;
- (Y) Emergency;
- (Z) Ultrasound;
- (AA) NICU transportation;
- (BB) GI laboratory;
- (CC) Miscellaneous; and
- (DD) Observation beds.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3150, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500,

[74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has Medicaid and SCHIP charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its Medicare cost report, the department establishes cost proxies to estimate costs in order to ensure recognition of Medicaid related costs.

(2) For the inpatient payment system effective for dates of admission before August 1, 2007, the department develops per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) For the inpatient payment system effective for dates of admission before August 1, 2007, the department also develops ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

(4) For the inpatient payment system effective for dates of admission on and after August 1, 2007, the department:

(a) Develops per diem proxies for accommodation cost centers using the hospital's per diem cost data within the affected same type of services; and

(b) Develops ratios of costs-to-charges (RCC) proxies for ancillary cost centers based on the hospital's aggregate ancillary costs to aggregate ancillary charges.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3200, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.-090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3250 Indirect medical education costs—Conversion factors, per diem rates, and per case rates. (1) For dates of admission before August 1, 2007, for each hospital with a graduate medical education program, the department removes indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap for conversion factor rebasing.

(2) For dates of admission before August 1, 2007, to arrive at indirect medical education costs for each component, the department:

(a) Multiplies Medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) Multiplies the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) For dates of admission before August 1, 2007, after the peer group's cost cap has been calculated, the department adds back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450.

(4) For dates of admission on and after August 1, 2007, the department:

(a) Uses the indirect medical costs in the calculation of the hospital DRG conversion factor, per diem rates, and per case rates.

(b) Uses the Medicare's indirect medical education factor matching the same period of the hospital Medicare cost

report used in calculating the hospital cost to estimate the hospital aggregate operating and capital costs. The indirect medical education costs were removed from the hospital aggregate operating and capital costs in determination of statewide standardized average operating and capital cost per discharge, per day, and per case amounts.

(c) To calculate the hospital-specific DRG conversion factor, per diem rates, and per case rates during rebasing. The department:

(i) Multiplies the statewide standardized labor portion of the operating amount by the most currently available facility-specific wage index established by Medicare that exists at the time of the Medicaid rebasing (to determine the labor portion, the department used the factor established by Medicare multiplied by the statewide operating standardized amount), then the nonlabor portion is added to the result to produce a hospital-specific operating amount; then

(ii) Multiplies the hospital-specific operating amount by 1.0 plus the most currently available operating indirect medical education factor established by Medicare that exists at the time of the Medicaid rebasing; then

(iii) Multiplies the statewide standardized capital amount by 1.0 plus the most currently available capital indirect medical education factor established by Medicare that exists at the time of the Medicaid rebasing; then

(iv) Adds this hospital-specific operating amount to the statewide standardized capital amount; then

(v) Adds the hospital-specific direct medical education portion adjusted for hospital-specific casemix index to the operating and capital amounts.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3250, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate setting purposes, the department groups hospitals into peer groups.

(2) The six hospital peer groups are:

(a) Group A, rural hospitals;

(b) Group B, urban hospitals without medical education programs;

(c) Group C, urban hospitals with medical education program;

(d) Group D, specialty hospitals or other hospitals not easily assignable to the other five groups;

(e) Group E, public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) program; and

(f) Group F, hospitals approved by the department of health (DOH) as critical access hospitals.

(3) For dates of admission before August 1, 2007, the department uses a cost cap at the seventieth percentile for hospitals in peer groups B and C for cost based conversion rate setting. All other peer groups are exempt from the cost caps for the following reasons:

(a) Peer group A hospitals because they are paid under the ratio of costs-to-charges (RCC) methodology for Medicaid claims.

(b) Peer group D hospitals because they are specialty hospitals without a common peer group on which to base comparisons.

(c) Peer group E hospitals because they are paid under the "full cost" public hospital certified public expenditure (CPE) program RCC methodology for inpatient claims.

(d) Peer group F hospitals because they are paid under the departmental weighted costs-to-charges (DWCC) methodology for most hospital claims. See WAC 388-550-2598(14) for the payment methods for inpatient detoxification unit, distinct psychiatric unit, and distinct rehabilitation unit claims.

(4) For dates of admission before August 1, 2007, the department calculates cost caps for peer groups B and C for cost based conversion rate setting based on the hospitals' base period costs after subtracting:

(a) Indirect medical education costs, in accordance with WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5) For dates of admission before August 1, 2007, the department uses the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor. After the peer group cost cap is calculated, the department adds back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) For dates of admission before August 1, 2007, in cases where corrections or changes in an individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, the department updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will result in a five percent or greater change in the seventieth percentile of costs calculated for either its previous peer group category, its new peer group category, or both.

(7) For dates of admission on and after August 1, 2007, the department continues to use the hospital peer groups in subsection (2) of this section to determine some rate setting and payment methods.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3300, filed 6/28/07, effective 8/1/07; 06-08-046, § 388-550-3300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-3300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.-200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3350 Outlier costs. (1) The information and processes described in subsections (1) through (5) of this section are applicable for claims with dates of admission before August 1, 2007.

(a) The department removes the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050.

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department adds the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department pays high-cost outlier claims from the outlier set-aside pool. The department calculates an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid management information system (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost diagnosis related group (DRG) outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department uses the individual hospital's outlier set-aside factor to reduce the hospital's CCBF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department funds the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements will be made to hospitals for outlier cases.

(6) For dates of admission on and after August 1, 2007, the department includes statistical outlier claims for calculation of the conversion factors, per diem rates, and per case rates, and does not establish an outlier set-aside pool. The department does not include statistical outlier claims for calibration of DRG relative weights.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3350, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.-090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3381 Payment methodology for acute PM&R services and administrative day services. The department's payment methodology for acute PM&R services provided by acute PM&R hospitals is described in this section.

(1) For dates of admission before August 1, 2007, the department pays an acute PM&R rehabilitation hospital according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500. For dates of admission on and after August 1, 2007, the department pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See WAC 388-550-3010 and 388-550-3460.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When the department authorizes administrative day(s) for a client as described in WAC 388-550-2561(8), the department pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed in the client's use during the administrative portion of the client's stay.

(4) The department pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital according to chapter 388-546 WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3381, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-3381, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3400 Case-mix index. (1) The department:

(a) Adjusts hospital costs used to calculate the conversion factor and per diem rates during the rebasing process by the hospital's case-mix index; and

(b) Calculates the case-mix index (CMI) for each individual hospital to measure the relative cost for treating Medicaid and SCHIP cases in a given hospital.

(2) The department calculates the CMI for each hospital using Medicaid and SCHIP admissions data from the individual hospital and the hospital's base period cost report. See WAC 388-550-3150. The CMI is calculated for each hospital by summing all relative weights for all claims in the dataset, and dividing the sum of the relative weights by the number of claims. That amount represents the relative acuity of the claims. The hospital-specific CMI is calculated as follows:

(a) The department multiplies the number of Medicaid and SCHIP admissions to the hospital for a specific DRG classification by the relative weight for that DRG classification. The department repeats this process for each DRG billed by the hospital.

(b) The department adds together the products in (a) of this subsection for all of the Medicaid and SCHIP admissions to the hospital in the base year.

(c) The department divides the sum obtained in (b) of this subsection by the corresponding number of Medicaid and SCHIP hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRG classifications. A CMI of less than 1.0 indicates a mix of patients in the less costly DRG classifications.

(3) The department recalculates each hospital's case-mix index periodically, but no less frequently than each time rebasing is done.

[Statutory Authority: RCW 74.08.090 and 74.09.500, 07-14-055, § 388-550-3400, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.-090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3450 Payment method for calculating Medicaid DRG conversion factor rates. (1) For Medicaid and SCHIP accommodation costs, the department:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the accommodation categories described in WAC 388-550-3150; then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total Medicaid and SCHIP days to arrive at total Medicaid accommodation costs per category for the three components.

(2) For ancillary costs the department:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's ancillary categories described in WAC 388-550-3150; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by Medicaid and SCHIP charges per category, as tracked by the Medicaid management information system (MMIS), to arrive at total Medicaid and SCHIP ancillary costs per category for the three components (operating, capital, and medical education).

(3) The department:

(a) Combines Medicaid and SCHIP accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of Medicaid and SCHIP cases during the base year to arrive at an average Medicaid and SCHIP cost per discharge; then

(c) For dates of admission before August 1, 2007, adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the Medicaid and SCHIP average cost by a factor determined by the department to stan-

standardize hospital costs to the common fiscal year end. The department adjust the hospital's Medicaid and SCHIP average cost by the hospital's specific case mix index.

(4) For dates of admission before August 1, 2007, the department caps the Medicaid and SCHIP average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, the department removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in department peer groups B or C, the department determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, the department adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350.

(5) For dates of admission before August 1, 2007, for an inflation adjustment and outlier set-aside adjustment, the department may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year;

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF.

(6) For dates of admission on and after August 1, 2007, the department establishes Medicaid DRG conversion factors for calculation of the Medicaid and SCHIP DRG payments.

(a) The department determines DRG conversion factors based on the estimated hospital operating, capital, and direct medical education costs from Medicaid and SCHIP fee-for-services and Health Option claims data for the most current state fiscal year, or "base year claims data." The claims data is designated by the department as the "base year claims data" used for the DRG conversion factor calculation process. The "base year claims data" consists of Medicaid and SCHIP fee-for-service and health options claims data for the most current state fiscal year (at the time the rebasing process takes place) from in-state acute care hospitals that are not a critical access hospital (CAH) or a long term acute care (LTAC) hospital. The detailed cost calculation is described in WAC 388-550-3150. Only base year claims grouped to a DRG classification that has a stable DRG relative weight are included in the DRG conversion factor calculation. Stable relative weight DRGs are defined in WAC 388-550-3100.

(b) The department calculates and adjusts hospital-specific operating, capital and direct medical education costs as follows:

(i) For hospital-specific operating costs (to determine the labor portion, the department used the factor established by Medicare multiplied by the statewide operating standardized amount) by the most currently available hospital-specific Medicare wage index established by Medicare that exists at the time of the Medicaid rebasing; then adds the nonlabor

portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific Medicare operating indirect medical education factor established by Medicare that exists at the time of the Medicaid rebasing); then divides that result by the hospital-specific Medicaid case-mix index; then

(ii) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific Medicare capital indirect medical education factor); then divides that result by the hospital-specific Medicaid case-mix; then

(iii) For hospital-specific direct medical education costs, the department divides hospital-specific direct medical education costs by the hospital-specific Medicaid case-mix; then

(iv) To make adjustments to hospital-specific costs derived in subsections (i) through (iii) of this subsection, the department uses:

(A) The Medicare wage indices and indirect medical education factors in effect for the Medicare inpatient prospective payment system (PPS) federal fiscal year that most closely matches the time period covered by the Medicare cost report used for these calculations; and

(B) The Medicaid case mix indices based on the recalibrated DRG relative weights applied to the base year claims data. Medicaid case mix index is described in WAC 388-550-3400.

(c) Calculates statewide operating and capital standardized amounts to adjust hospital-specific operating and capital costs as follows. The department:

(i) Divides the statewide aggregate adjusted operating costs by the statewide aggregate number of discharges in the base year claims data (cost and discharges are described in subsection (a) and (b) of this subsection); and

(ii) Divides the statewide aggregate adjusted capital costs by the statewide aggregate number of discharges in the base year claims data (costs and discharges described in subsection (a) and (b) of this section.

(d) The department makes hospital-specific adjustments to the statewide operating and capital standardized amounts as follows:

(i) To determine the labor portion, the department used the factor established by Medicare multiplied by the statewide operating standardized amount. The labor portion of the hospital-specific operating standardized amount is multiplied by the most currently available hospital-specific Medicare wage index established by Medicare that exists at the time of the Medicaid rebasing; then the nonlabor portion is added to the result; then the result is multiplied by (1.0 plus the most currently available hospital-specific Medicare operating indirect medical education factor established by Medicare that exists at the time of the Medicaid rebasing). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(ii) Capital standardized amount is multiplied by (1.0 plus the most current available hospital-specific Medicare capital indirect medical education factor that has been published at the point the rate setting calculation takes place during the rebasing process).

(e) To determine hospital-specific DRG conversion factors, the department sums for each hospital:

(i) The adjusted operating standardized amount;

(ii) The adjusted capital standardized amount; and

(iii) The direct medical education cost per discharge adjusted for hospital-specific case-mix index.

(f) The department adjusts the hospital-specific DRG conversion factors for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the rebased inpatient payment system implementation year.

(g) The department may adjust the hospital-specific DRG conversion factors by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services for the rebasing implementation year.

(h) The department may make other necessary adjustments as directed by the legislature.

(i) The hospital's specific DRG conversion factor may not be changed unless the inpatient payment system is rebased or the legislature authorized the changes.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3450, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.-200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3460 Payment method—Per diem

rate. (1) For dates of admission before August 1, 2007 the department established per diem rates for:

(a) Inpatient chronic pain management as indicated in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as indicated in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as indicated in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as indicated in WAC 388-550-4500.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diems for the services identified in subsection (1), except for the community psychiatric hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of psychiatric services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates separate statewide standardized per diem rates for the following categories:

(i) Rehabilitation services—Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services—Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services—Chemically using pregnant (CUP) women program services are identified as

any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all Medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the system. These claims include any statistical outliers. These statewide standardized amounts serve as the basis for calculating per diem rates for each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs. Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department adjusts the labor portion of the hospital-specific operating costs by the most currently available hospital-specific Medicare wage index established by Medicare that exists at the time of the Medicaid rebasing; then adds the nonlabor portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific Medicare operating indirect medical education factor established by Medicare that exists at the time of the Medicaid rebasing); then divides that result by the hospital-specific Medicaid case-mix index; then

(B) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific Medicare capital indirect medical education factor); then divides the result by the hospital-specific Medicaid case-mix; then

(iii) The department then sums the costs and days for all included hospitals for each service, and calculates each services' statewide standardized weighted average cost per day amounts, weighted based on number of days.

(d) Once the department establishes the statewide standardized amounts, hospital-specific per diem rates for each specialty service are calculated.

(i) Starting with the statewide standardized operating amount, the department multiplies the labor portion of the amount (to determine the labor portion, the department used the factor established by Medicare multiplied by the statewide operating standardized amount) by the most currently available hospital-specific wage index established by Medicare that exists at the time of the Medicaid rebasing, as published by Medicare. This adjustment is made to reflect wage differences incurred by hospitals in different regions of the state. The department then adds the nonlabor portion to the result.

(ii) The department adjusted operating and capital amounts reflect the indirect costs associated with approved teaching programs. The department adjusts for the indirect costs by multiplying the operating and capital amounts by (1.0 plus the most currently available hospital-specific Medicare indirect medical education factor in the Medicare final rule for the operating and capital components). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(iii) The department then adds to the operating and capital amounts the hospital-specific direct medical education cost per day (hospital-specific direct medical education cost per day adjusted for hospital-specific case-mix index).

(iv) Finally, the department adjusts the facility-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(e) Specialty service claims are not eligible for high outlier payments. See WAC 388-550-3700.

(4) For dates of admission on and after August 1, 2007, the department establishes hospital-specific per diem rates for psychiatric services provided by in-state noncritical access hospitals that are free-standing psychiatric hospitals, acute care hospitals with psychiatric distinct part units, or other acute care hospitals.

(a) The department identifies psychiatric claims for hospitals meeting the criteria in this subsection as all claims from free-standing psychiatric hospitals, and all claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at the acute care hospitals. The department includes all claims from freestanding psychiatric hospitals, regardless of AP-DRG assignment.

(b) To determine facility-specific payment rate per day for psychiatric services, the department uses the greater of the estimated costs per diem of the:

(i) Hospital's inpatient psychiatric claims in the base year dataset; or

(ii) Statewide average of the estimated costs of the hospital's inpatient psychiatric claims (as described in subsection (4)(a)) in the base year claims including adjustments for regional wage differences and for differences in medical education costs.

(c) The department calculates average cost per day amounts for each hospital and then makes adjustments to the average cost per day amounts to reflect changes in the indirect medical education factor and hospital-specific wage index between the base year and the implementation year.

(d) Finally, the department adjusts the hospital-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(5) For dates of admission on and after August 1, 2007, for hospitals not meeting the criteria in subsection (4), the department calculates per diem rates using the same method used for rehabilitation, detoxification and CUP women program payments described in this section, except that the department uses only the psychiatric claims from those facilities identified as qualifying for hospital-specific rates.

(6) For dates of admission on and after August 1, 2007, for freestanding rehabilitation facilities, the department uses the per diem rate established for rehabilitative services rather than a facility-specific rate.

(7) For dates of admission on and after August 1, 2007, for claims that are classified into AP-DRG classifications that do not have enough claims volume to establish stable relative weights, and that are not specialty claims as described in this section, the department also uses a per diem rate.

(a) These types of claims are less homogeneous than the specialty claims described in this section, and the costs of these claims are more variable than the costs of those that are included under the DRG payment method. The department conducts significant analyses to establish per diem rates based on groupings that would distinguish between higher cost per day claims and lower cost per day claims. As part of this analysis, the department analyzes costs per day based on the following criteria for groupings, which are not mutually exclusive:

- (i) Neonatal claims, based on assignment to major diagnostic category (MDC) 15;
- (ii) Burn claims based on assignment to MDC 22;
- (iii) AP-DRG assignments that include primarily medical procedures;
- (iv) AP-DRG assignments that include primarily surgical procedures;
- (v) Cranial procedure claims, based on specific cranial procedure AP-DRG classifications, and
- (vi) MDC assignment.

(b) Based on the analyses of cost per day amounts for each grouping criteria identified in subsection (7)(a), the department identified four nonspecialty service groupings appropriate for establishing per diem payments. These are:

- (i) Neonatal claims, based on assignment to MDC 15;
- (ii) Burn claims based on assignment to MDC 22;
- (iii) AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified in this subsection; and
- (iv) AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified in this subsection.

(c) For each service group, except for burn cases, the department calculates a per diem rate for each hospital based on the aggregate statewide weighted average cost per day for the service after adjusting costs for regional wage differences and differences in graduate medical education program costs. Unstable burn claim per diem rates are based on the average cost per day of unstable burn claims at Harborview Medical Center, which treats the vast majority of burn cases in the state.

(d) The per diem calculations are based on the estimated costs of the claims for each service group in the base year, including both fee-for-service and healthy options claims data. After determining the statewide weighted average cost

per day after these adjustments, the department calculates the per diem rate for each hospital for each service group by adjusting the statewide weighted average cost per day amount for each hospital based on its hospital-specific wage index and medical education program costs.

(e) Because of the variability of the cost of claims in unstable AP-DRG classifications, the department developed an outlier policy for these per diem payments, similar to the outlier methodology recommended for the DRG payment method.

(f) Claims that are not in the specialty service groupings indicated in subsection (3)(a) and (b), may qualify for a high outlier payment if the claim qualifies under the high outlier criteria. See WAC 388-550-3700.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3460, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3470 Payment method—Bariatric surgery—Per case rate. (1) The department:

(a) Pays for bariatric surgery provided in designated department-approved hospitals when all criteria established in WAC 388-550-2301 and 388-550-3020 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC 388-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the department determines the per case rate by using a hospital-specific Medicare fee schedule rate the department used to pay for bariatric surgery.

(3) For dates of admission on and after August 1, 2007, the department determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the department's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the department:

(i) Inflates the hospital-specific operating, capital, and direct medical education routine costs from the hospital's Medicare cost report fiscal year to the mid-point of the state fiscal year.

(ii) Divides the labor portion of the hospital-specific operating costs by the hospital-specific Medicare wage index in effect for the Medicare inpatient prospective payment system federal fiscal year that most closely matches the time period covered by the Medicare cost report used for these calculations.

(b) To determine the statewide standardized weighted average cost per case by using the adjusted hospital-specific operating and capital costs derived in (a) of this subsection, the department:

(i) Adjusts the hospital-specific operating and capital costs to remove the indirect costs associated with approved medical education programs; then

(ii) Calculates the operating standardized amount by dividing statewide aggregate adjusted operating costs by the statewide aggregate number cases in the base year claims data; then

(iii) Calculates the capital standardized amount by dividing statewide aggregate adjusted capital costs by the statewide aggregate number of cases in the base year claims data.

(c) To make hospital-specific adjustments to the statewide operating and capital standardized amounts, the department:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all in-state hospitals operating standardized amount after making adjustments for the wage index and the indirect medical education. The department:

(A) To determine the labor portion, uses the factor established by Medicare multiplied by the statewide operating standardized amount, then multiplies the labor portion of the operating standardized amount by (1.0 plus the most currently available hospital-specific Medicare wage index); then

(B) Adds the nonlabor portion of the operating standardized amount to the labor portion derived in (c)(i)(A) of this subsection; then

(C) Multiplies the amount derived in (c)(i)(B) of this subsection by 1.0 plus the most currently available hospital-specific Medicare operating indirect medical education factor to derive the operating standardized amount for bariatric services; then

(D) Adjusts the hospital-specific operating standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(E) Calculates the statewide bariatric operating payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(i)(D) of this subsection for each hospital approved by the department to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of in-state hospitals approved by the department to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all in-state hospitals capital standardized amount after adjusting for the indirect medical education. The department:

(A) Multiplies the amount derived in (b)(iii) of this subsection by (1.0 plus the most currently available hospital-specific Medicare capital indirect medical education factor) to derive the adjusted indirect medical education capital standardized amount for bariatric services.

(B) Adjusts the hospital-specific capital standardized amount for bariatric services for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(C) Calculates the statewide bariatric capital payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(ii)(B) of this subsection for each hospital approved by the department to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of in-state hospitals approved by the department to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the in-state hospitals hospital-specific direct medical education weighted cost per case multiplied by the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base

year data and the payment system implementation year. The department calculates the statewide bariatric direct medical education standardized payment per case by:

(A) Multiplying the hospital-specific direct medical education weighted cost per case for each hospital approved by the department to provide bariatric services by the CMS PPS input price index; then

(B) Totaling the hospital-specific amounts derived in (iii)(A) of this subsection for each hospital approved by the department to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the department sums for each hospital the in-state statewide bariatric operating payment per case, and the in-state statewide bariatric capital payment per case, and the hospital-specific direct medical education payment per case. (For critical border hospitals, the direct medical education payment per case is limited at the highest direct medical education payment per case amount for the in-state hospitals approved by the department to provide bariatric services.)

(e) The department adjusts the hospital-specific bariatric payment per case amount by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services.

(f) The department may make other necessary adjustments as directed by the legislature (i.e., rate rebasing and other changes as directed by the legislature).

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3470, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3500 Hospital annual inflation adjustment determinations. (1) Effective each state fiscal year, except rebase implementation years, the department may adjust all cost-based conversion factors (CBCF), per diem rates, and per case rates, by an inflation factor (vendor rate increase), as determined by the state legislature and supported in the state's budget. The department does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

(2) For dates of admission on and after August 1, 2007, except for rebase implementation years, the department makes adjustments to the hospital's DRG conversion factors, per diem rates, and per case rates, by an inflation factor (vendor rate increase), as authorized and determined by the legislature and supported in the state's budget.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 07-14-055, § 388-550-3500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.-090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. The department applies the following payment rules when an eligible client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit:

(1) The department does not pay a hospital for a nonemergency case when the hospital transfers the client to another hospital.

(2) The department pays a hospital that transfers emergency cases to another hospital, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) For dates of admission:

(i) Before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay.

(ii) On or after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem rate by dividing the hospital's DRG allowed amount for payment for the appropriate DRG by that DRG's statewide average length of stay for the AP-DRG classification as determined by the department.

(3) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) The department's length of stay data to determine the number of medically necessary days for a client's hospital stay.

(4) The department:

(a) Pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment; and

(b) Applies the outlier payment methodology if a transfer case qualifies:

(i) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(ii) For dates of admission on or after August 1, 2007, as a high outlier.

(5) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(a) The department's maximum payment to the discharging hospital is the full DRG payment.

(b) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (2) of this section.

(6) The department makes all applicable claim payment adjustments to claims for client responsibility, third party liability, Medicare, etc.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3600, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3600, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.-200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers. This section applies to inpatient hospital claims paid under

the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under per diem payment methodology.

(1) For dates of admission before August 1, 2007, a Medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date January 1, 2001 or after.

(3) For dates of admission before August 1, 2007, the department determines payment for Medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and in-state children's hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Three examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after, and before August 1, 2007).

| Examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after). | | | | | | |
|--|------------------------|------------------------------|-----------------------------|---|-------------------------------|--------------------------------|
| Allowed Charges | Applicable DRG Payment | Three times App. DRG Payment | Allowed Charges > \$33,000? | Allowed Charges > Three times App. DRG Payment? | DRG High-Cost Outlier Payment | Hospital's Individual RCC Rate |
| \$17,000 | \$5,000 | \$15,000 | No | Yes | N/A | 64% |
| *33,500 | 5,000 | 15,000 | Yes | Yes | **\$5,240 | 64% |
| 10,740 | 35,377 | 106,131 | No | No | N/A | 64% |

| Medicaid Payment calculation example for allowed charges of: | Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%) |
|--|---|
| *\$33,500 | Allowed charges |
| - \$33,000 | The greater amount of 3 x app. DRG pymt (\$15,000) or \$33,000 |
| \$500 | |
| x 48% | 75% of allowed charges x hospital RCC rate (nonpsych DRGs/nonin-state children's) (75% x 64% = 48%) |
| \$240 | Outlier portion |
| + \$5,000 | Applicable DRG payment |
| **\$5,240 | Outlier payment |

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) For dates of admission before August 1, 2007, a Medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a Medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007 the department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for

the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department determined estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims

grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.

(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection (16) of this section.

The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the non-covered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission. To qualify as a high outlier claim, when a claim is grouped to medical, surgical, burn, or neonatal DRG service category, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable per diem base allowed amount for payment.

The department performs retrospective prepay utilization review on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.

Specifically, this formula is:

$$N = (Z^2 * S^2) / R^2, \text{ where}$$

- The Z statistic for 90 percent confidence is 1.64
- S = the standard deviation for the AP-DRG classification, and
- R = acceptable error range, per sampling unit

If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classifica-

tion during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.

The DRG classification assigned to the per diem payment method, that are in one of the following major services categories in subsection (16)(a) through (d) of this section, qualify for determination to ascertain if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of a AP-DRG relative weight. A claim in a DRB classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:

(a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;

(b) Burn claims based on assignment to MDC 22;

(c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and

(d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.

(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the Medicaid or SCHIP DRG paid and per diem paid claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for Medicaid or SCHIP DRG paid and per diem paid claims is as follows:

(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the non-covered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.

(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:

(i) For DRG paid claims grouped to nonneonatal or non-pediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For nonspecialty service category per diem paid claims grouped to nonneonatal and nonpediatric DRG classifications, and for nonspecialty service category per diem paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment allowed amount; and

(iv) For nonspecialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all nonspecialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment indicated in (b)(i) through (iv) of this subsection, respectively, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. Hospitals paid with the payment method used for out-of-state hospitals are paid using the percent of outlier adjustment factor identified in (c)(iii) of this subsection. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Used as indicated in WAC 388-550-4800 to calculate payment for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

| DRG high outlier | | | | | | |
|--|--|---|---|---|--|--------------------------------|
| Three examples for Medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data. | | | | | | |
| Total Submitted Charges Minus Noncovered Charges | Base DRG Payment Allowed Amount ¹ | 175% of Base DRG Payment Allowed Amount | Department Determined Estimated Costs Are Greater Than \$50,000? ² | Department Determined Estimated Costs Than 175% of Base DRG Payment Allowed Amount? | Total DRG High Outlier Claim Payment Allowed Amount ^{3,4} | Hospital's Individual RCC Rate |
| \$95,600 | \$28,837 | \$50,465 | Yes | Yes | \$38,761 | 65% |
| \$64,500 | \$28,837 | \$50,465 | No | Yes | \$28,837 | 65% |
| \$77,000 | \$28,837 | \$50,465 | Yes | No | \$28,837 | 65% |

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$$\$6,300 \times 4.5773 = \$28,837 = \text{Base DRG allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$95,600 \times 65\% = \$62,140 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria (in this example \$50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$$\$62,140 - \$50,465 = \$11,675 \times 85\% = \$9,924 = \text{High outlier portion allowed amount}$$

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$$\$28,837 + \$9,924 = \$38,761$$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$$\$6,300 \times 4.5773 = \$28,837 = \text{Base DRG allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$64,500 \times 65\% = \$41,925 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

(\$41,925 - \$50,465 = (\$8,540)) x 85% = (\$7,259), which is converted to \$0. Also, \$41,925 is not greater than \$50,000,

so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$$\$28,837 + \$0 = \$28,837$$

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$$\$6,300 \times 4.5773 = \$28,837 = \text{Base DRG allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$77,000 \times 65\% = \$50,050 = \text{Department determined estimated costs}$$

estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = high outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$50,050 - \$50,465 = (\$415)) \times 85\% = (\$353)$, which is converted to \$0. Also, \$50,050 is greater than \$50,000, but not greater than \$50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$$\$28,837 + \$0 = \$28,837$$

| Per Diem High Outlier | | | | | | |
|--|---|--|---|--|---|--------------------------------|
| Three examples for Medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data. | | | | | | |
| Total Submitted Charges Less Total Noncovered Charges | Base Per Diem Payment Allowed Amount ¹ | 175% of Base Per Diem Payment Allowed Amount | Department Determined Estimated Costs Are Greater Than \$50,000? ² | Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount? | Total Per Diem High Outlier Claim's Payment Allowed Amount ^{3,4} | Hospital's Individual RCC Rate |
| \$100,000 | \$25,000 | \$43,750 | Yes | Yes | \$47,313 | 70% |
| \$64,000 | \$25,000 | \$43,750 | No | Yes | \$25,000 | 70% |
| \$75,000 | \$35,000 | \$61,250 | Yes | No | \$35,000 | 70% |

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$$\$1,000 \text{ (rate)} \times 25 \text{ (days)} = \$25,000 = \text{Base per diem allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$100,000 \times 70\% = \$70,000 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$$(\$70,000 - \$43,750 = \$26,250) \times 85\% = \$22,313 = \text{High outlier portion allowed amount}$$

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$$\$25,000 + \$22,313 = \$47,313$$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$$\$1,000 \times 25 = \$25,000 = \text{Base per diem allowed amount}$$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$$\$64,500 \times 70\% = \$45,150 = \text{Department determined estimated costs}$$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$45,150 - \$43,750 = \$1,400)$, but \$45,150 is not greater than \$50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$$\$25,000 + \$0 = \$25,000$$

Example three: (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$\$1,000 \times 35 = \$35,000 = \text{Base per diem allowed amount}$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$75,000 \times 70\% = \$52,500 = \text{Department determined estimated costs}$

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$52,500 - \$61,250 = (8,750)) \times 85\% = (\$7,438)$, which is converted to \$0. Also, \$52,500 is greater than \$50,000, but not greater than \$61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$\$35,000 + \$0 = \$35,000$

(18) The department makes all applicable claim payment adjustments for client responsibility, third party liability, Medicare, etc., to the payment.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 03-13-053, § 388-550-3700, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3700, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303 and 447.2652. 99-06-046, § 388-550-3700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3800 Rebasing and recalibration. (1)

The department rebases most of the rates used in the Medicaid inpatient payment system once every three years. Changes to the inpatient hospital rate calculations and rate-setting methods involved in this rebasing process are implemented pursuant to the rebasing of the rate system

(a) To determine costs for that rebasing process, the department uses:

(i) Each in-state hospital's Medicare cost report for the hospital fiscal year that ends during the calendar year that the rebasing base year designated by the department begins; and

(ii) Inpatient Medicaid and SCHIP claims data for the twelve-month period designated by the department as the rebasing base year.

(b) The rebasing process updates rates for the diagnosis related group (DRG), per diem, and per case rate payment methods.

(c) Other inpatient payment system rates (e.g., the ratio of costs-to-charges (RCC) rates, departmental weighted

costs-to-charges (DWCC) rates, administrative day rate, and swing bed rate) are rebased on an annual basis.

(d) The department increases inpatient hospital rates only when mandated by the state legislature. These increases are implemented according to the base methodology in effect, unless otherwise directed by the legislature.

(2) The department periodically recalibrates diagnosis-related group (DRG) relative weights, as described in WAC 388-550-3100, but no less frequently than each time the rate rebasing process described in subsection (1) takes place. The department makes recalibrated relative weights effective on the rebasing implementation date, which can change with each rebasing process.

(3) When recalibrating DRG relative weights without rebasing, the department may apply a budget neutrality factor (BNF) to hospitals' conversion factors to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the prior payment system.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 05-06-044, § 388-550-3800, filed 2/25/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3900 Payment method—Bordering city hospitals and critical border hospitals. (1) For dates of admission before August 1, 2007, under the diagnosis-related group (DRG) payment method:

(a) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a bordering city hospital with no Medicare cost report (Form 2552-96) for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) For dates of admission before August 1, 2007, the department calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b) For a bordering city hospital with no Medicare cost report submitted to the department, its RCC is based on the Washington in-state average RCC.

(3) For dates of admission before August 1, 2007, the department pays a bordering city hospital using the same payment methods as for an in-state hospital for allowed covered charges related to medically necessary services identified on an outpatient hospital claim.

(4) For dates of admission on and after August 1, 2007, with the exception of outpatient payment to hospitals previously paid under the outpatient prospective payment system (OPPS) methodology and critical border hospitals located in bordering cities, the department pays bordering city hospitals for allowed covered charges related to medically necessary

services based on the inpatient and outpatient hospital rates and payment methods used to pay out-of-state hospitals. See WAC 388-550-4000.

(5) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an inpatient hospital claim:

(a) Under one of the inpatient DRG, RCC, per diem, or per case rate payment methods that are similar to the methods used to pay in-state hospitals;

(b) Using a DRG conversion factor, per diem, or per case rate based on the statewide standardized average that will result in payment that does not exceed the payment that would be made to any in-state hospital for the same service, including medical education components of payments; and

(c) Using a hospital's specific RCC rate based on the hospital's annual Medicare cost report information for the applicable period. For a critical border hospital that does not submit a Medicare cost report to the department, the department determines which in-state hospital has the lowest RCC rate and uses that rate as the critical border hospital's RCC rate.

(6) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. Those rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital. Bordering city hospitals' base period claims data is analyzed during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies as a critical border hospital.

(7) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an outpatient hospital claim using the outpatient hospital payment methods and payment criteria identified in WAC 388-550-6000 and 388-550-7200. The department limits payment to bordering city hospitals that are noncritical border hospitals to the lesser of the billed charges or the calculated payment amount.

(8) The department makes applicable claim payment adjustments for client responsibility, third party liability, Medicare, etc., to claim payments.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3900, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.-200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4000 Payment method—Emergency services—Out-of-state hospitals. The department pays for emergency services that are covered by the department and provided to eligible medical assistance clients as follows:

(1) For dates of admission before August 1, 2007, the department pays:

(a) Inpatient hospital claims for emergency services provided in out-of-state hospitals, the lesser of:

(i) Billed charges; or

(ii) The weighted average of ratio of cost-to-charge (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(b) Outpatient hospital claims for emergency services provided in out-of-state hospitals, the lesser of:

(i) Billed charges; or

(ii) The weighted average of outpatient hospital rates for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(2) For dates of admission on and after August 1, 2007, the department pays:

(a) Inpatient hospital claims for emergency services provided in out-of-state hospitals under the inpatient diagnostic related group (DRG), ratio of costs-to-charges (RCC), per diem, and per case rate payment methods, whether or not the hospital has submitted a Medicare cost report (Form 2552-96) to the department for the rebasing year. The department:

(i) Pays an out-of-state hospital and bordering city hospital that is not a critical border hospital, using the lowest of the in-state inpatient hospital rates, and excludes payment for medical education (out-of-state hospitals are not eligible to receive payment for medical education). This rate is the same rate calculated for all rural hospitals in Washington for the same service (excluding DWCC rates that are paid to in-state critical access hospitals).

(ii) Pays a department designated critical border hospital according to WAC 388-550-3900.

(iii) Limits payment to out-of-state hospitals and bordering city hospitals that are noncritical border hospitals to the lesser of the billed charges or the calculated payment amount.

(b) Pays outpatient hospital claims for emergency services provided in out-of-state hospitals that are:

(i) Bordering city hospitals, including critical border hospitals previously paid under the outpatient prospective payment system (OPPS) methodology for dates of admission before August 1, 2007, in accordance with WAC 388-550-7200; and

(ii) Out-of-state hospitals, including bordering city hospitals not previously paid under the OPPS methodology, the lesser of:

(A) Billed charges; or

(B) The in-state average hospital outpatient rate times the allowed covered charges for medically necessary services.

(3) The department does not pay for nonemergency hospital services provided to medical assistance clients in out-of-state hospitals unless the facility is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

(i) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

(ii) Authorized services are paid according to subsections (1) and (2) of this section.

(4) The department makes all applicable claim payment adjustments for clients responsibility, third party liability, Medicare, etc., to claim payments.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, the department considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs) conversion factors, RCC rates, per diem rates, per case rates, etc.; or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) The department determines a new hospital's:

(a) CBCF as the average of the CBCF of all hospitals within the same department peer group for dates of admission before August 1, 2007.

(b) Conversion factor, per diem rate, or per case rate, to be the statewide average rate for the conversion factor, category of per diem rate, or per case rate, for dates of admission on and after August 1, 2007, adjusted by the geographically appropriate hospital specific Medicare wage index.

(3) The department determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) The department considers that a change in hospital ownership does not constitute a new hospital.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4200 Change in hospital ownership.

(1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital must notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department sets the new provider's cost-based conversion factor (CBCF), conversion factor, per diem rates, per case rate, at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department sets for a hospital formed as a result of a merger:

(a) A blended CBCF, conversion factor, per diem rate, per case rate, based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500. Partial year cost reports will not be used for this purpose.

(5) The department recaptures depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4200, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4300 Hospitals and units exempt from the DRG payment method.

(1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) For dates of admission before August 1, 2007, subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to Medicaid-eligible clients:

(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are paid through the DRG payment method (see WAC 388-550-4400):

(i) General assistance programs; and

(ii) Other state administered programs.

(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.

(c) Peer group F hospitals (critical access hospitals).

(d) Rehabilitation units when the services are provided in department-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

The department uses the same criteria as the Medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Inpatient rehabilitation services provided to clients eligible under the following programs are covered and paid through the DRG payment method (see WAC 388-550-4400 for exceptions):

(i) General assistance programs; and

(ii) Other state-only administered programs.

(e) Out-of-state hospitals excluding hospitals located in designated bordering cities as described in WAC 388-501-

0175. Inpatient services provided in out-of-state hospitals to clients eligible under the following programs are not covered or paid by the department:

- (i) General assistance programs; and
 - (ii) Other state administered programs.
- (f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

- (i) A negotiated per diem rate; or
- (ii) DRG.

(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with Medicare certified distinct psychiatric units. The department uses the same criteria as the Medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are paid through the DRG payment method:

- (A) General assistance programs; and
- (B) Other state administered programs.

(ii) Mental health division (MHD) designees that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through a MHD are paid through the department's payment system.

(3) The department limits inpatient hospital stays for dates of admission before August 1, 2007 that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, *Length of Stay by Diagnosis and Operation, Western Region*, unless the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

(5) For dates of admission on and after August 1, 2007, the department exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to Medicaid-eligible clients:

(a) Peer group E hospitals as described in WAC 388-550-3300(2), i.e., hospitals participating in the department's certified public expenditure (CPE) payment program. See WAC 388-550-4650.

(b) Peer group F hospitals, i.e., critical access hospitals. See WAC 388-550-2598.

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. Inpatient psychiatric services, involuntary treatment act services, and detoxification services provided in out-of-state hospitals are not covered or paid by the department or a MHD designee. The department does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:

- (i) General assistance programs; and
- (ii) Other state-administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. The department, or the military hospital, may elect or arrange for one of the following payment methods in lieu of the RCC payment method:

- (i) Per diem payment method; or
- (ii) DRG payment method.

(g) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. A MHD designee that arranges to pay a hospital and/or a designated distinct psychiatric unit of a hospital directly, may use the department's payment methods or contract with the hospitals to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(6) For dates of admission on and after August 1, 2007, the department has established an average length of stay (ALOS) for each DRG classification. The DRG ALOS is based on the claims data used during the rebasing period. For DRGs with an exceptionally low volume of claims, the department uses a proxy DRG ALOS. The DRG ALOS is used as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the department's DRG ALOS benchmark or prior authorized LOS:

(a) For a psychiatric inpatient stay, the hospital must obtain approval for additional days beyond the prior authorized days from the MHD or the MHD designee who prior authorized the admission. See WAC 388-550-2600;

(b) For an acute physical medicine and rehabilitation (PM&R) or a long term acute care (LTAC) stay, the hospital must obtain approval for additional days beyond the prior authorized days from the department unit that prior authorized the admission. See WAC 388-550-2561 and 388-550-2590;

(c) For an inpatient hospital stay for detoxification for a chemical dependent pregnant CUP client, see WAC 388-550-1100;

(d) For other medical inpatient stays for detoxification, see WAC 388-550-1100 and subsection (7) of this section;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC 388-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the department may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

(7) If subsection (6)(d) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4300, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-4300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4400 Services—Exempt from DRG payment. (1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) Subject to the restrictions and limitations in this section, for dates of admission before August 1, 2007, the department exempts the following services for Medicaid clients from the DRG payment method:

(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.

(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services. These services are also exempt from the DRG payment method

when funded by the department through the general assistance programs and any other state administered program.

(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. These are Medicaid program services and are not funded by the department for the general assistance programs or any other state administered program.

(e) Acute physical medicine and rehabilitation services provided in department-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. See WAC 388-550-4300 (2)(d). Rehabilitation services provided to clients under the general assistance programs and any other state-only administered program are also reimbursed through the RCC payment method.

(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals. Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii) Other state administered programs.

(g) Chronic pain management treatment provided in department-approved pain treatment facilities.

(h) Administrative day services. The department pays administrative days based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.

(i) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid through the general assistance programs and any other state administered program.

(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, pancreas, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.

(k) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3470.

(3) Inpatient services provided through a managed care plan contract are paid by the managed care plan.

(4) Subject to the restrictions and limitations in this section, for dates of admission on and after August 1, 2007, the department exempts the following services for Medicaid and SCHIP clients from the DRG payment method. This policy also applies to covered services paid through the general assistance programs and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services.

(b) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically-using pregnant (CUP) women program by a certified hospital. These are Medicaid program services and are not covered or funded by the department through the general assistance programs or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. A mental health division (MHD) designee that arranges to pay a hospital directly for psychiatric services, may use the department's payment methods or contract with the hospital to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(e) Chronic pain management treatment provided in a hospital approved by the department to provide that service.

(f) Administrative day services. The department pays administrative days based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. A hospital must request an administrative day designation on a case-by-case basis. The department may designate part of a client's stay to be paid an administrative day rate upon review of the claim and/or client's medical record.

(g) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG (AP DRG) relative weight. Claims grouped to DRG 469 or DRG 470 will be denied payment.

(h) Organ transplants that involve heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The department pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method.

(i) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3020 and 388-550-3470.

(j) Services provided by a critical access hospital (CAH).

(k) Services provided by a hospital participating in the certified public expenditure (CPE) payment program. The CPE "hold harmless" provision allows a reconciliation that is described in WAC 388-550-4670.

(l) Services provided by a long term acute care (LTAC) hospital.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4400, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-550-4400, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4400, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—Inpatient RCC rate, administrative day rate, hospital outpatient rate, and swing bed rate. (1) The inpatient ratio of costs-to-charges (RCC) allowed amount is the hospital's covered charges on a claim multiplied by the hospital's inpatient RCC rate. The department limits this RCC allowed amount for

payment to the hospital's allowable usual and customary charges.

(a) The department calculates a hospital's RCC rate by dividing allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) The department bases the RCC rate calculation on data from the hospital's "as filed" annual Medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(c) The department updates a hospital's inpatient RCC rate annually after the hospital sends its "as filed" hospital fiscal year Medicare cost report to the centers for Medicare and Medicaid services (CMS) and to the department.

(i) In situations where a delay in submission of the CMS Medicare cost report to the Medicare fiscal intermediary is granted by Medicare, the department may adjust the RCC rate based on a department-determined method.

(ii) Prior to calculating the RCC rate, the department excludes department nonallowed costs and nonallowable revenues. Costs and revenues attributable to a change in ownership are one example of what the department does not allow in the calculation process.

(2) The department limits a hospital's RCC payment to one hundred percent of its allowed covered charges.

(3) The department establishes the basic inpatient hospital RCC allowed amount by multiplying the hospital's assigned RCC rate by the allowed covered charges for medically necessary services. The department deducts client responsibility and third-party liability (TPL), and makes other applicable payment program adjustments to the basic allowed amount to determine the actual payment due.

(4) For dates of admission:

(a) Before August 1, 2007, the department uses the RCC payment method to pay:

(i) DRG-exempt hospitals identified in WAC 388-550-4300; and

(ii) Any hospital for DRG-exempt services identified in WAC 388-550-4400. See the services identified in WAC 388-550-4400 (2)(g), (h), and (k) for an exception to this policy.

(b) For dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay:

(i) Transplant services identified in WAC 388-550-4400;

(ii) DRG and per diem payment method high outlier payments;

(iii) Long term acute care (LTAC) hospital services not covered under the LTAC per diem rate; and

(iv) Other services specified by the department.

(5) For dates of admission before August 1, 2007, the department pays in-state and bordering city hospitals that lack sufficient Medicare cost report data to establish a hospital specific RCC, using the weighted average in-state:

(a) RCC rate for applicable inpatient services identified in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate as provided in WAC 388-550-6000.

(6) The department pays out-of-state hospitals for covered services as described in WAC 388-550-4000.

(7) The department identifies all in-state hospitals that have hospital specific RCC rates, and calculates the weighted average in-state RCC rate annually by dividing the depart-

ment-determined total allowable costs of these hospitals by the department-determined total patient-related revenues associated with those costs.

(8) The department allows hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(a) Upon request, the department's nursing facility rate-setting staff provides the department's hospital rate-setting staff with the statewide weighted average nursing facility Medicaid payment rate each year to update the all-inclusive administrative day rate on November 1.

(b) The department does not pay for ancillary services provided during administrative days.

(c) The department identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(9) The department calculates the weighted average in-state hospital outpatient rate annually by multiplying the weighted average in-state RCC rate by the outpatient adjustment factor.

(10) For hospitals that have their own hospital specific inpatient RCC rate, the department calculates the hospital's specific hospital outpatient rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor.

(11) The outpatient adjustment factor:

(a) Must not exceed 1.0; and

(b) Is updated annually. At the time the outpatient adjustment factor is updated, the hospital outpatient rate for the hospital is adjusted.

(12) The department establishes the basic hospital outpatient allowed amount for a claim as provided in WAC 388-550-6000 and 388-550-7200. The department deducts any client responsibility and any third-party liability (TPL), and makes any other applicable payment program adjustments to the allowed amount to determine the actual payment due.

(13) The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The department does not allow payment for acute inpatient level of care for swing bed days when a client is receiving department-approved nursing service level of care in a swing bed.

(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200, and may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not

allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4500, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4600 Hospital selective contracting program. This section applies only for dates of admission before July 1, 2007. The hospital selective contracting program ends on June 30, 2007.

(1) The department designates selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to Medicaid clients. Selective contracting areas are based on historical patterns of hospital use by Medicaid clients.

(2) The department requires Medicaid clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department exempts from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department designates hospitals as remote when they meet the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred Medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities;

(e) Out-of-state hospitals located in nonbordering cities, and out-of-state hospitals in bordering cities not designated as selective contracting areas;

(f) Peer group E hospitals; and

(g) Peer group F hospitals (critical access hospitals).

(4) The department:

(a) Negotiates with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services provided to Medicaid clients.

(b) Calculates its maximum financial obligation for a Medicaid client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) Applies NCFs to Medicaid clients only. (The department uses CBCFs in calculating payments for medical care services clients.)

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-12-040, § 388-550-4600, filed 5/30/07, effective 7/1/07; 06-08-046, § 388-550-4600, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4600, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4670 CPE payment program—"Hold harmless" provision. To meet legislative requirements, the department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure (CPE) payment program. Under the hold harmless provision, hospitals eligible for payments under the CPE payment program will receive no less in combined state and federal payments than they would have received under the methodologies otherwise in effect as described in this section.

(1) For each state fiscal year, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the state fiscal year (SFY) as the sum of:

(a) The total payments for inpatient claims for patients admitted during the fiscal year, calculated by repricing the claims using:

(i) For SFYs 2006 and 2007, the inpatient payment method in effect during SFY 2005;

(ii) For SFYs 2008 and beyond, the payment method that would otherwise be in effect during the CPE payment program year if the CPE payment program had not been enacted; and

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(2) For each SFY, the department determines total payments made under the program during the fiscal year, including the allowable federal portion of inpatient claims and disproportionate share hospital (DSH) payments, and the state and federal shares of any supplemental upper payment limit payments.

(3) The amount determined in subsection (2) of this section is subtracted from the amount calculated in subsection (1) of this section to determine the gross state grant amount necessary to hold the hospital harmless. Prepaid hold harmless grants prepaid for the same SFY referred to in subsection (2) of this section are deducted from the gross hold harmless amount to determine the net amount due to or from the hospital.

(a) The department calculates an interim hold harmless grant amount approximately ten months after the SFY to include the paid claims for the same SFY admissions. Claims are subject to utilization review prior to the interim hold harmless calculation.

(b) The department calculates the final hold harmless grant amount at such time as the final allowable federal portions of program payments are determined. The procedure is the same as the interim grant calculation but it includes all additional claims that have been paid or adjusted since the interim hold harmless calculation. Claims are subject to utilization review prior to the final calculation of the hold harmless amount due to or from the hospital.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-4670, filed 6/29/07, effective 8/1/07. Statutory Authority: RCW 74.08.090,

74.09.500, and 2005 c 518 § 209(9), 06-11-100, § 388-550-4670, filed 5/17/06, effective 6/17/06.]

WAC 388-550-4700 Payment—Non-SCA participating hospitals. This section applies only for dates of admission before July 1, 2007. The hospital selective contracting program ends on June 30, 2007.

(1) In a selective contracting area (SCA), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

| <u>County</u> | <u>Community Travel Distance Standard</u> |
|---------------|---|
| Adams | 25 miles |
| Asotin | 15 miles |
| Benton | 15 miles |
| Chelan | 15 miles |
| Clallam | 20 miles |
| Clark | 15 miles |
| Columbia | 19 miles |
| Cowlitz | 15 miles |
| Douglas | 20 miles |
| Ferry | 27 miles |
| Franklin | 15 miles |
| Garfield | 30 miles |
| Grant | 24 miles |
| Grays Harbor | 23 miles |
| Island | 15 miles |
| Jefferson | 15 miles |
| King | 15 miles |
| Kitsap | 15 miles |
| Kittitas | 18 miles |
| Klickitat | 15 miles |
| Lewis | 15 miles |
| Lincoln | 31 miles |
| Mason | 15 miles |
| Okanogan | 29 miles |
| Pacific | 21 miles |
| Pend Oreille | 25 miles |
| Pierce | 15 miles |
| San Juan | 34 miles |
| Skagit | 15 miles |
| Skamania | 40 miles |
| Snohomish | 15 miles |
| Spokane | 15 miles |
| Stevens | 22 miles |
| Thurston | 15 miles |
| Wahkiakum | 32 miles |
| Walla Walla | 15 miles |
| Whatcom | 15 miles |
| Whitman | 20 miles |
| Yakima | 15 miles |

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemergency admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA pays a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare Part A subject to the Medicaid maximum allowable as established in WAC 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-12-040, § 388-550-4700, filed 5/30/07, effective 7/1/07. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment methods—State administered programs. Subsections (1) through (11) of this section apply to hospital payment methods for state administered programs for dates of admission before August 1, 2007. Subsections (12) through (19) of this section apply to hospital payment methods for state administered programs for dates of admission on and after August 1, 2007.

(1) Except as provided in subsection (2) of this section, the department uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to pay hospitals at reduced rates for covered services provided to a client who is not eligible under a Medicaid program, the SCHIP program, or alien emergency medical (AEM) program and:

- (a) Who qualifies for the general assistance unemployable (GAU) program; or
- (b) Is involuntarily detained under the Involuntary Treatment Act (ITA).

(2) The department exempts the following services from the state-administered programs' payment methods and/or reduced rates:

(a) Detoxification services when the services are provided under a department-assigned provider number starting with "thirty-six." (The department pays these services using the Title XIX Medicaid RCC payment method.)

(b) Program services provided by department-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (The department pays these services through cost settlement as described in WAC 388-550-2598.)

(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (The department

these services through the "full cost" public hospital certified public expenditure (CPE) payment program (see WAC 388-550-4650).)

(3) The department determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX Medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX Medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) The department determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate = current Title XIX Medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:

State-administered programs' DRG CF = current Title XIX Medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) The department determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative weight (see subsection (6) of this section for how the department determines payment for state-administered program claims that qualify as DRG high-cost outliers).

(6) For state-administered program claims that qualify as DRG high-cost outliers, the department determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

| High-cost Outlier Calculations for Qualifying Claims State-administered Programs (for admission dates January 1, 2001 and after) | | | | | | | | | | | | | | |
|--|-----|-------------------------|-----|---------------------|-----|-----|-----|---------------|-----|-----|-----|-------------------------|-----|---------------------|
| In-state Children's Hospitals Allowed charges | (-) | > of \$33000 or 3 x DRG | (=) | Charges > threshold | (x) | RCC | (x) | 1 (-) Ratable | (x) | 85% | (=) | Outlier Addition Amount | (+) | *DRG Allowed Amount |

| High-cost Outlier Calculations for Qualifying Claims State-administered Programs (for admission dates January 1, 2001 and after) | | | | | | | | | | | | | | |
|--|-----|-------------------------|-----|---------------------|-----|-----|-----|---------------|-----|------|-----|-----------------------|-----|----------------------|
| Psychiatric DRGs 424-432 Allowed charges | (-) | > of \$33000 or 3 x DRG | (=) | Charges > threshold | (x) | RCC | (x) | 1 (-) Ratable | (x) | 100% | (=) | Outlier Add-on Amount | (+) | * DRG Allowed Amount |
| All other qualifying claims Allowed charges | (-) | > of \$33000 or 3 x DRG | (=) | Charges > threshold | (x) | RCC | (x) | 1 (-) Ratable | (x) | 60% | (=) | Outlier Add-on Amount | (+) | * DRG Allowed Amount |
| *Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount | | | | | | | | | | | | | | |

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8) The department determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9) To calculate a hospital's ratable that is applied to both the Title XIX Medicaid RCC rate and the Title XIX Medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, the department:

(a) Adds the hospital's Medicaid revenue (Medicaid revenue as reported by department of health (DOH) includes all Medicaid revenue and all other medical assistance revenue) and Medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 Medicare cost report received by the department at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific Medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific Medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital-Medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an in-state-average ratable and an in-state-average ratable factor used for new hospitals with no prior year history.

(10) The department updates each hospital's ratable annually on August 1.

(11) The department:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX Medicaid DRG CBCF x (one minus the prior ratable)

(12) For dates of admission on and after August 1, 2007, the department pays for services provided to a client eligible for a state administered program based on state-administered program rates. The state administered program rates are established independently from the process used in setting the Medicaid payment rates. The state administered program rates may not be changed unless the legislature authorizes the changes. The department uses the ratable factor and equivalency factor to keep the state administered program payment rates at the same level they were at before the state Medicaid rates are rebased.

(13) The table in this subsection shows a comparison of the payment policy for the department's inpatient payment system for dates of admission before August 1, 2007, and the inpatient payment system effective for dates of admission on and after August 1, 2007. Under this inpatient payment system effective August 1, 2007, the per diem rates are used to pay for many services previously paid using the RCC payment method.

The following table indicates differences in policy for the two inpatient payment systems:

| | Inpatient payment system for dates of admission before August 1, 2007 | Inpatient payment system for dates of admission on and after August 1, 2007 |
|-------------------------|---|---|
| Stable DRGs | DRG Grouper v 14.1 | DRG grouper v 23.0 |
| Unstable/Medical DRGs | RCC | Per diem |
| Unstable Surgical DRGs | RCC | Per diem |
| Unstable Neonate DRGs | RCC | Per diem |
| Psych | RCC | Per diem |
| Rehab | RCC | Per diem |
| Detox | RCC | Per diem |
| Transplant | RCC | RCC |
| Military hospitals | RCC | RCC |
| HIV | RCC | Not separately defined |
| Chronic pain management | Per diem | Per diem |
| Bariatric surgery | Per case rate | Per case rate |
| CUP | Not separately defined | Per diem |
| Burns | Not separately defined | Per diem |

See specific sections in the chapter 388-550 WAC to determine how the department pays hospitals participating in the critical access hospital (CAH) program, the long term acute care (LTAC) program, and the certified public expenditure (CPE) payment program.

(14) Due to changes in payment methodologies established for the inpatient payment system effective August 1, 2007, the department has established the following state administered program rates used for dates of admission on and after August 1, 2007:

(a) State administered program DRG conversion factor for claims grouped under stable DRG classifications services.

(b) State administered program per diem rates for claims grouped under the following specialty service categories:

- (i) CUP;
- (ii) Detoxification; and
- (iii) Physical medicine and rehabilitation.

(c) State administered program per diem rates for the claims grouped to unstable DRG classifications under the following nonspecialty service categories:

- (i) Surgical;
- (ii) Medical;
- (iii) Burns; and
- (iv) Neonate and pediatric.

(d) State administered program per diem rates for claims grouped under psychiatric services.

(e) State administered program per case rate for claims grouped under bariatric services.

(f) State administered program RCC rates for claims grouped under transplant services.

(15) This subsection describes the state administered program (DRG) conversion factor and payment calculation processes used by the department to pay claims paid using the DRG payment method. The department pays for services grouped to a stable DRG classification that are provided to clients eligible for a state administered program based on use of a DRG conversion factor and a DRG relative weight. This process is similar to the payment method used to pay for Medicaid and SCHIP services that are grouped to a stable DRG classification.

(a) The department's state administered program DRG conversion factor calculation process is as follows:

(i) For in-state and critical border hospitals, the hospital's specific DRG conversion factor that is used to calculate pay-

ment for a state administered program claim, is based on the Medicaid conversion factor adjusted by the most available ratable factor and the applicable equivalency factor. Mathematically the calculation is:

State administered program DRG CF =
 ((Medicaid DRG CF x applicable Equivalency Factor) x most available ratable factor)

(ii) For in-state and critical border hospitals that do not have a current state administered program DRG conversion factor, the state administered program conversion factor is the hospital's specific proposed Medicaid conversion factor multiplied by the average applicable equivalent factor and average applicable ratable.

(iii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program DRG conversion factor is the lowest in-state Medicaid DRG conversion factor multiplied by the average ratable and equivalency factor.

(b) The department's state administered program DRG equivalency factor calculation process is as follows:

(i) The equivalency factor is a factor used to hold the hospital's specific state administered program DRG conversion factor or rates at the same level before and after the Medicaid DRG rate is rebased. Mathematically the calculation is:

Equivalency factor = (State administered program DRG CF / (Medicaid DRG CF x ratable))

(ii) The department may make an adjustment to the equivalency factor to address the differences in the relative weight values of the two DRG grouper versions due to the recalibration of the weights.

(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.

(c) The department's DRG payment calculation process for DRG classifications grouped to stable DRG relative weights is as follows:

(i) The department determines the allowed amount for the inlier portion of the state-administered program DRG payment calculation. Mathematically the calculation is:

State administered program DRG inlier portion allowed amount of the payment = (State administered program DRG CF x DRG relative weight)

(ii) The department determines the high outlier claim calculation for the state administered program DRG pay-

ment. See WAC 388-550-3700 for more information about high outlier qualification and calculation processes. Mathematically the calculation is:

State-administered program DRG inlier and outlier portion allowed amount of the payment = (State-administered program DRG CF x DRG relative weight) + outlier adjustment

(iii) The outlier payment adjustment calculation for a state administered program claim is different than the outlier payment calculation for a Medicaid claim. The outlier adjustment for a state administered program claim is adjusted by the ratable factor.

(iv) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to non-neonatal DRGs and non-pediatric DRGs, equals one hundred seventy-five percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment in hospitals other than Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center.

(v) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to neonatal DRGs, pediatric DRGs, equals one hundred fifty percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment when the claim is from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

(vi) The outlier transfer provision is applied for the calculation of services paid under the state administered program DRG payments.

(vii) Refer to the Medicaid percent of outlier adjustment factor described in WAC 388-550-3700 and (d) of this subsection for how the percent of outlier adjustment factor is reduced by a ratable to determine the outlier portion allowed amount for the claim.

(d) The department determines the outlier portion allowed amount calculation for the state-administered program high outlier claim DRG payment as follows. Mathematically the calculation is:

State administered program outlier portion allowed amount of claim = ((Covered charges x RCC) - outlier threshold) x (Percent of outlier adjustment factor x ratable factor)

(i) A claim is an outlier claim when the claim cost (covered charges x RCC) is greater than both the fixed loss amount of fifty thousand dollars and one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(ii) The outlier threshold used in calculation of the outlier payment adjustment will always be one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.

(16) This subsection describes the state-administered program per diem rate and payment calculation for the fol-

lowing specialty service categories and unstable DRG non-specialty service categories.

(a) The per diem rate is separately established for each of the following services:

- (i) CUP;
- (ii) Detoxification;
- (iii) Physical medicine and rehabilitation;
- (iv) Surgical;
- (v) Medical;
- (vi) Burns; and
- (v) Neonate and pediatric.

(b) The per diem rate calculation process for CUP, detoxification, physical medicine and rehabilitation, surgical, medical, burns, and neonate and pediatric services is, for in-state and critical border hospitals, the hospital's specific state administered program per diem rate is based on the Title XIX Medicaid rates multiplied by the most available ratable factor and the equivalency factor. Mathematically the calculation is:

State administered program per diem rate =
((Hospital's specific Medicaid per diem x ratable factor) x Equivalency factor)

(c) The per diem equivalency factor calculation process is as follows:

(i) The per diem equivalency factor is a factor used to hold the aggregate payment for all non-Medicaid claims grouped under per diem payment method at the same level before and after the per diem Medicaid rate is rebased. The equivalency factor is the calculated based on the estimate non-Medicaid per diem, the Medicaid per diem, and the hospital's specific ratable factor. Mathematically the calculation is:

Equivalency factor =
(Estimated state administered program per diem rate/
(Medicaid per diem rate x ratable))

(ii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program per diem rate is the lowest in-state Medicaid per diem rate multiplied by the average ratable and equivalency factor.

(iii) The state administered program per diem rate is an estimate based on the actual payment per day. The actual payment per day equals the aggregate payment amount (inflated from the base year to the implementation year) divided by the number of days associated with the aggregate costs.

(iv) For a hospital with more than twenty state administered program claims that grouped in the base year data to DRG classifications that are paid using the per diem payment method, a hospital's specific equivalency factor is established based on the hospital's data.

(v) For a hospital with less than twenty state administered program claims that grouped in the base year data to DRG classifications are paid using the per diem payment method, an average equivalency factor is established based on the hospital data base of all hospitals.

(d) The state administered program per diem allowed amount of payment calculation process for CUP, detoxification, and physical medicine and rehabilitation services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

The high outlier and transfer policy is not applied to payment calculations for CUP, detoxification, and physical medicine and rehabilitation services.

(e) The state administered program per diem allowed amount of payment calculation process for surgical, medical, burns, and neonate services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

(i) The outlier policy is applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services (see WAC 388-550-3700). Refer to the state administered program outlier DRG adjustment payment calculation for the outlier calculation.

(ii) The transfer policy is not applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services.

(17) The state administered program per diem rate and payment calculation for psychiatric services is as follows:

(a) The department uses a payment method similar to the method used to pay for Medicaid psychiatric services, for state administered program psychiatric services provided to clients eligible for those services. Psychiatric services provided to state administered program clients are paid using a psychiatric per diem rate. The per diem rate calculation process for state administered program psychiatric services is as follows:

(i) For in-state hospitals, the hospital's specific state administered program psychiatric per diem rate used to calculate the allowed amount for payment is based on the Title XIX Medicaid rate adjusted by a ratable factor specified by the legislature to reduce the Medicaid psychiatric per diem to a state program per diem. Mathematically the calculation is:

State administered program psychiatric per diem rate =

Medicaid psychiatric per diem x a ratable factor specified by the legislature to reduce the Medicaid psychiatric per diem to a state program per diem.

(ii) For hospitals located outside the state of Washington, including bordering city hospitals, critical border hospitals, and other out-of-state hospitals, psychiatric services and involuntary treatment act (ITA) services are not covered or paid by the department.

(b) The per diem payment calculation process for state-administered program psychiatric services is as follows. Mathematically the calculation is:

Psychiatric payment =

State administered program hospital's specific per diem rate x patient stay LOS recognized by the department's MHD designee for payment

(i) Outlier payment and transfer policies are not applied to state administered program psychiatric claims.

(ii) The ratable factor was provided to the department by the legislature.

(18) This subsection describes the state administered program per case rate and payment processes for bariatric surgery services.

(a) The department limits provision of bariatric surgery services to medical assistance clients to hospitals that are approved by the department to provide those services. Bariatric surgery services provided to a medical assistance client by an approved hospital must also be prior authorized by the department for the hospital to receive payment from the department for those services. Effective August 1, 2007, the department approved bariatric surgery services programs at the Sacred Heart Medical Center, the University of Washington Medical Center, and the Oregon Health Science University. The department may approve other programs based on department discretion.

(b) The department calculates the state administered program per case rate for bariatric surgery services by multiplying the hospital's specific Medicaid per case rate for bariatric surgery services by the hospital's specific ratable factor and DRG-equivalency factor. Mathematically the calculation is:

State administered program per case rate =

Medicaid per case rate x hospital's specific ratable factor x DRG equivalency factor

The per case payment rate for bariatric surgery services is an all-inclusive rate. No outlier provision is applied to the per case rate.

(19) This subsection describes the state administered program RCC rates and payment calculation processes for transplant services and other RCC paid services. Transplant services provided to a client eligible for those services through a state administered program are paid using the RCC payment method. There are some other services that may be paid using the RCC payment method, e.g., services provided by military hospitals when no other payment method is agreed upon by the department and the hospital. The state administered program RCC rate is calculated by multiplying the Medicaid RCC rate by the ratable factor. Mathematically the calculation is:

State administered program RCC rate = Medicaid RCC x ratable factor

(20) The department may pay for authorized psychiatric indigent inpatient claims submitted by an in-state community hospital designated as an institution for mental diseases (IMD) using state funds when such funds are provided by the state legislature specifically for this purpose.

(21) The department's policy for payment on state-administered program claims that involve third party liability (TPL) and/or client responsibility payments is the same policy indicated in the table in WAC 388-550-2800, except that when the department determines the payment on the claim, it applies state-administered program rates, not Medicaid or SCHIP rates, when comparing the lesser of billed charges or the allowed amount on the claim.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4800, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-4800, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 74.09.500. 04-19-113, § 388-550-4800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-4800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652. 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4800, filed

2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by section 1902 (a)(13)(A) of the Social Security Act (42 USC 1396 (a)(13)(A)) and RCW 74.09.730, the department makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 USC 1396r-4;

(b) It satisfies all the requirements of department rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the hospital fiscal year or Medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid Medicaid claims during the state fiscal year (SFY) two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "Disproportionate share hospital (DSH) cap" means the maximum amount per state fiscal year that the state can distribute in DSH payments to hospitals (statewide DSH cap), or the maximum amount of DSH payments a hospital may receive during a state fiscal year (hospital-specific DSH cap).

(e) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the department which the department uses to verify Medicaid patient eligibility and patient days.

(f) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the department during a state fiscal year. For a critical access hospital (CAH), the DSH cap is based strictly on the net cost to the hospital of providing services to uninsured patients.

(g) "Low income utilization rate (LIUR)" means the sum of these two percentages: (1) The ratio of payments received by the hospital for patient services provided to clients under Medicaid (including managed care) and state-administered programs, plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus (2) the ratio of inpatient charity care charges (excluding contractual allowances), divided by total billed charges for inpatient services. The department uses LIUR as one criterion to determine a hospital's eligibility for the low

income disproportionate share hospital (LIDSH) program. To qualify for LIDSH, a hospital's LIUR must be greater than twenty-five percent.

(h) "Medicaid inpatient utilization rate (MIPUR)" means the number of inpatient days of service provided by a hospital to Medicaid clients during its hospital fiscal year or Medicare cost report year, divided by the number of inpatient days of service provided by that hospital to all patients during the same period.

(i) "Medicare cost report year" means the twelve-month period included in the annual cost report a Medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that is not a peer group E hospital or a small rural hospital and is located inside the state of Washington or in a designated bordering city. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or Medicare cost report year, or to a state fiscal year.

(m) "Small rural hospital" means a hospital that is not a peer group E hospital, has fewer than seventy-five acute licensed beds, is located inside the state of Washington, and is located in a city or town with a nonstudent population of no more than seventeen thousand one hundred fifteen in calendar year 2006 as determined by the Washington State office of financial management estimate. The nonstudent population ceiling increases cumulatively by two percent each succeeding state fiscal year.

(n) "Uninsured patient" means an individual who does not have health insurance that would apply to the hospital service the individual sought and received. An individual who did have health insurance that applied to the hospital service the individual sought and received, is considered an insured individual for DSH program purposes, even if the insurer did not pay the full charges for the services. When determining the cost of a hospital service provided to an uninsured patient, the department uses as a guide whether the service would have been covered under Medicaid.

(4) To be considered for a DSH payment for each SFY, a hospital located in the state of Washington or in a designated bordering city must submit to the department a completed and final DSH application by the due date. The due date will be posted on the department's website.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital submits a completed DSH application for that specific year, if it satisfies the utilization rate requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a Medicaid inpatient utilization rate (MIPUR) greater than one percent; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's eligibility for any DSH program, the department uses the criteria in this section and the information obtained from the DSH application submitted by the hospital, subject to the following:

(a) Charity care. If the hospital's DSH application and audited financial statements for the relevant fiscal year do not agree on the amount for charity care, the department uses the lower amount listed. For purposes of calculating a hospital's LIUR, the department allows a hospital to claim charity care amounts related to inpatient services only. A hospital must submit a copy of its charity care policy for the relevant fiscal year as part of the hospital's DSH application.

(b) Total inpatient hospital days. If the hospital's DSH application and its Medicare cost report do not agree on the number of total inpatient hospital days, the department uses the higher number listed to determine the hospital's MIPUR. Labor and delivery days count towards total inpatient hospital days. Nursing facility and swing bed days do not count towards total inpatient hospital days.

(7) The department administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH);

(c) General assistance-unemployable disproportionate share hospital (GAUDSH);

(d) Small rural disproportionate share hospital (SRDSH);

(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(g) Public hospital disproportionate share hospital (PHDSH); and

(h) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) Except for IMDDSH, the department allows a hospital to receive any one or all of the DSH payment adjustments it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section). See WAC 388-550-5130 regarding IMDDSH. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the department calculates DSH payments due an eligible hospital using data from the hospital's base year. The department does not use base year data for

GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The department's total DSH payments to a hospital for any given SFY cannot exceed the individual hospital's annual DSH limit (also known as the hospital-specific DSH cap) for that SFY. Except for critical access hospitals (CAHs), the department determines a hospital's DSH cap as follows:

(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care organization (MCO) plans;

(b) Less the amount paid by the state under the non-DSH payment provision of the Medicaid state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients;

(d) Less any cash payments made by or on behalf of uninsured patients; and

(e) Plus any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to uninsured patients. In calculating a CAH's DSH cap, the department deducts payments received by the hospital from and on behalf of the uninsured patients from the hospital's costs of services for the uninsured patients.

(12) In any given federal fiscal year, the total of the department's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the department's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the department will adjust DSH payments to each hospital to account for the amount overpaid. The department makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) NRIADSH;

(e) GAUDSH;

(f) PIIDSH;

(g) IMDDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the department will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program WACs for description of how amounts to be recouped are determined.

(15) The total amount the department may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed pools. Any changes in payment amount to a hospital in a particular DSH pool means a redistribution of payments within that DSH pool. When necessary, the department will recoup from hospitals to make additional payments to other hospitals within that DSH pool.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the department will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH pool. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH pool.

(b) If an individual hospital has been underpaid by a specified amount, the department will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH pool. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH pool.

(17) All information submitted by a hospital related to its DSH application is subject to audit. The department may audit any, none, or all DSH applications for a given state fiscal year. The department determines the extent and timing of the audits. For example, the department may choose to do a desk review upon receipt of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the department will recoup the overpayment amount, in accordance with the provisions of RCW 74.09.220 and 43.20B.695.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific state fiscal year. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full state fiscal year in which the rules are adopted.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-4900, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4900, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp. s. c 25. 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.-090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.-050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4925 Eligibility for DSH programs—New hospital providers. To be eligible for disproportionate share hospital (DSH) payments, a new hospital provider must have claims data, audited financial statements, and an "as filed" or finalized Medicare cost report for the hospital base year used by the department in calculating DSH payments for the state fiscal year (SFY) for which the hospital provider is applying. See WAC 388-550-4900(9).

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-4925, filed 6/29/07, effective 8/1/07.]

WAC 388-550-4935 DSH eligibility—Change in hospital ownership. (1) For purposes of eligibility for disproportionate share hospital (DSH) payments, a change in hospital ownership has occurred if any of the criteria in WAC 388-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the department in writing

no later than thirty days after the change in ownership becomes final. The notice must include the new entity's fiscal year end.

(3) A hospital that did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted, and changes ownership after that date is not eligible for DSH unless it continues to be classified as an acute care hospital serving pediatric and/or adult patients. See WAC 388-550-4900(5) for the obstetric services and utilization rate requirements for DSH eligibility.

(4) If the fiscal year reported on a hospital's Medicare cost report does not exactly match the fiscal year reported on the hospital's DSH application to the department, and if therefore the utilization data reported to the department do not agree, the department will use as the data source the document that gives the higher number of total inpatient hospital days for purposes of calculating the hospital's Medicaid inpatient utilization rate (MIPUR). See WAC 388-550-4900(6)(b).

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-4935, filed 6/29/07, effective 8/1/07.]

WAC 388-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) A hospital that is not a peer group E hospital but serves the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(5).

(2) Hospitals considered eligible under the criteria in subsection (1) of this section receive LIDSH payments. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) The department determines LIDSH payments to each LIDSH eligible hospital using three factors:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR);

(b) The hospital's Medicaid case mix index (CMI) as determined by the department; and

(c) The hospital's Title XIX Medicaid discharges for the applicable hospital fiscal year.

(4) The department calculates the LIDSH payment to an eligible hospital as follows. The department:

(a) Divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiplies the result derived in subsection (a) by the hospital's most recent DRG payment method Medicaid case mix index, and then by the hospital's base year Title XIX discharges; then

(c) Converts the product to a percentage of the sum of all such products for individual hospitals; and

(d) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(5) For DSH program purposes, a hospital's Medicaid CMI is the average diagnosis related group (DRG) weight for all of the hospital's Medicaid DRG-paid claims during the state fiscal year used as the base year for the DSH application. It is possible that the CMI the department uses for DSH calculations will not be the same as the CMI the department uses in other hospital rate calculations.

(6) After each applicable state fiscal year has ended, the department will not make changes to the LIDSH payment distribution that has resulted from calculations identified in subsection (4) of this section. The department will recalculate the LIDSH payment distribution only when the applicable state fiscal year has not yet ended at the time the alleged need for an LIDSH adjustment is identified, and if the department considers the recalculation necessary and appropriate under its regulations.

(7) Consistent with the provisions of subsection (6) of this section, the department applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs in accordance with the provisions of WAC 388-550-4900 (13) through (16).

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5000, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5000, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5000, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4, 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5125 Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH). (1) Effective for dates of admission on and after July 1, 2003, a hospital is eligible for the psychiatric indigent inpatient disproportionate share hospital (PIIDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900(5);
- (b) Is not designated an institution for mental diseases (IMD);
- (c) Provides services to clients eligible under the psychiatric indigent inpatient (PII) program. See WAC 388-865-0217 for more information regarding the PII program; and
- (d) Is located within the state of Washington. A hospital located out-of-state, including a hospital located in a designated bordering city, is not eligible to receive PIIDSH payments.

(2) PIIDSH is available only for emergency, voluntary inpatient psychiatric care. PIIDSH is not available for charges for nonhospital services associated with the inpatient psychiatric care.

(3) The department makes PIIDSH payments to an eligible hospital on a claim-specific basis.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5125, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5125, filed 3/30/06, effective 4/30/06.]

WAC 388-550-5130 Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH) and institution for mental diseases (IMD) state grants. (1) A psychiatric hospital owned and operated by the state of Washington is eligible to receive payments under the institution for mental diseases disproportionate share hospital (IMDDSH) program.

(2) For the purposes of the IMDDSH program, the following definitions apply:

(a) "Institution for mental diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen

beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(b) "Psychiatric community hospital" means a psychiatric hospital other than a state-owned and operated hospital.

(c) "Psychiatric hospital" means an institution which is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons. The term applies to a Medicare-certified distinct psychiatric care unit, a Medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a Medicare-certified acute care hospital.

(d) "State-owned and operated psychiatric hospital" means eastern state hospital and western state hospital.

(3) Except as provided in subsection (4) of this section, a psychiatric community hospital, regardless of location, is not eligible to receive:

- (a) IMDDSH payments; or
- (b) Any other disproportionate share hospital (DSH) payment from the department. See WAC 388-550-4800 regarding payment for psychiatric claims for clients eligible under the medical care services programs.

(4) A psychiatric community hospital within the state of Washington that is designated by the department as an IMD is eligible to receive IMDDSH payment if:

- (a) IMDDSH funds remain available after the amounts appropriated for state-owned and operated psychiatric hospitals are exhausted; and
 - (b) The legislature provides funds specifically for this purpose.
- (5) A psychiatric community hospital within the state of Washington that is designated by the department as an IMD is eligible to receive a state grant amount from the department if the legislature appropriates funds specifically for this purpose.

(6) An institution for mental diseases located out-of-state, including an IMD located in a designated bordering city, is not eligible to receive a Washington state grant amount.

(7) Under federal law, 42 USC 1396r-4 (h)(2), the state's annual IMDDSH expenditures are capped at thirty-three percent of the state's annual statewide DSH cap. This amount represents the maximum that the state can spend in any given fiscal year on IMDDSH, but the state is under no obligation to actually spend that amount.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5130, filed 6/29/07, effective 8/1/07.]

WAC 388-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH). (1) A hospital is eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900;
- (b) Is an in-state or designated bordering city hospital;
- (c) Provides services to clients eligible under the medical care services program; and
- (d) Has a Medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The department determines the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

(3) The department makes GAUDSH payments to a hospital on a claim-specific basis.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5150, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5150, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5150, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—Small rural disproportionate share hospital (SRDSH). (1) The department makes small rural disproportionate share hospital (SRDSH) payments to qualifying small rural hospitals.

To qualify for an SRDSH payment, a hospital must:

- (a) Not be a peer group E hospital;
- (b) Meet the criteria in WAC 388-550-4900(5);
- (c) Have fewer than seventy-five acute licensed beds; and
- (d) Be an in-state hospital. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRDSH payments;

(2) In addition, for the SRDSH program to be implemented for state fiscal year (SFY) 2008, which begins on July 1, 2007, the city or town must have a nonstudent population of no more than seventeen thousand one hundred fifteen in calendar year 2006, as determined by the Washington state office of financial management estimate.

For each subsequent SFY, the nonstudent population ceiling is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for SRDSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRDSH payment from the total dollars in the pool using percentages established as follows:

(a) At the time the SRDSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies the Medicaid payment amounts made by the department to the individual hospital during the SFY two years prior to the current SFY for which DSH application is being made. These Medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total Medicaid payment amount determined in subsection (i) by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised Medicaid payment amount; and

(iii) Divides the revised Medicaid payment amount for the individual hospital by the sum of the revised Medicaid

payment amounts for all qualifying hospitals during the same period.

(4) The department's SRDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured patients for that hospital unless an exception is required by federal statute or regulation.

(5) The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5200, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5200, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25, 04-12-044, § 388-550-5200, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5200, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.-010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5210 Payment method—Small rural indigent assistance disproportionate share hospital (SRI-ADSH) program. (1) The department makes small rural indigent assistance disproportionate share hospital (SRI-ADSH) program payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRIADSH payment, a hospital must:

- (a) Not be a peer group E hospital;
- (b) Meet the criteria in WAC 388-550-4900(5);
- (c) Have fewer than seventy-five acute licensed beds; and
- (d) Be an in-state hospital that provided charity services to clients during the base year. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRIADSH payments; and

(e) Be located in a city or town with a nonstudent population of no more than seventeen thousand one hundred fifteen in calendar year 2006, as determined by the Washington State office of financial management estimate. This estimated nonstudent population ceiling is used for SFY 2008, which begins July 1, 2007. For each subsequent SFY, the nonstudent population ceiling is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for SRI-ADSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the SRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for all hospitals qualifying for SRIADSH.

(c) Any qualifying hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other qualifying hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The department's SRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients for that hospital unless an exception is required by federal statute or regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5210, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5210, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5210, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5210, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5220 Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH). (1) The department makes nonrural indigent assistance disproportionate share hospital (NRIADSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an NRIADSH payment, a hospital must:

- (a) Not be a peer group E hospital;
- (b) Meet the criteria in WAC 388-550-4900(5);
- (c) Be a hospital that does not qualify as a small rural hospital as defined in WAC 388-550-4900 (3)(m); and
- (d) Be an in-state or designated bordering city hospital that provided charity services to clients during the base year. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.

(3) The department pays hospitals qualifying for NRIADSH payments from a legislatively appropriated pool. The department determines each hospital's individual NRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the NRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the hospital's base year data and audited financial statements.

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the NRIADSH revised costs by dividing the hospital's revised cost amount by the total revised charity costs for all qualifying hospitals during the same period.

(4) The department's NRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients for the hospital unless an exception is required by federal statute or regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5220, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5220, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5220, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5220, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5400 Payment method—Public hospital disproportionate share hospital (PHDSH). (1) The department's public hospital disproportionate share hospital (PHDSH) program is a public hospital program for:

(a) Public hospitals located in the state of Washington that are:

- (i) Owned by a public hospital district; and
- (ii) Not certified by the department of health (DOH) as a critical access hospital;
- (b) Harborview Medical Center; and
- (c) University of Washington Medical Center.

(2) The PHDSH payments to a hospital eligible under this program may not exceed the hospital's disproportionate share hospital (DSH) cap calculated according to WAC 388-550-4900(10). The hospital receives only the federal matching assistance percentage of the total computable payment amount.

(3) Hospitals receiving payment under the PHDSH program must provide the local match for the federal funds through certified public expenditures (CPE). Payments are limited to costs incurred by the participating hospitals.

(4) A hospital receiving payment under the PHDSH program must submit to the department federally required Medicaid cost report schedules apportioning inpatient and outpatient costs, beginning with the services provided during state fiscal year 2006. See WAC 388-550-5410.

(5) PHDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the department will recoup PHDSH payments first, but only from hospitals that received total inpatient and DSH payments above the hold harmless level, and only to the extent of the excess amount above the hold harmless level. See WAC 388-550-4900 (13) and (14), and WAC 388-550-4670.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5400, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5400, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5400, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5400, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5410 Medicaid cost report schedules.

(1) A certified public expenditure (CPE) hospital must annually submit to the department federally required Medicaid cost report schedules, using schedules approved by the centers for Medicare and Medicaid services (CMS), that apportion inpatient and outpatient costs to Medicaid clients and uninsured patients for the service year, as follows:

- (a) Title XIX fee-for-service claims;
- (b) Medicaid managed care organization (MCO) plan claims;
- (c) Uninsured patients (individuals who are not covered under any health care insurance plan for the hospital service provided). The cost report schedules for uninsured patients must not include services that Medicaid would not have covered had the patients been Medicaid eligible; and
- (d) State-administered program patients. State-administered program patients are reported separately and are not to be included on the uninsured patient cost report schedule. The department will provide provider statistics and reimbursements (PS&R) reports for the state-administered program claims.

(2) The department requires each CPE hospital to submit Medicaid cost report schedules to the department for services provided to patients discharged on or after July 1, 2005.

(3) A CPE hospital must:

(a) Use the information on individualized PS&R reports provided by the department when completing the Medicaid cost report schedules. The department provides the hospital with the PS&R reports at least thirty days prior to the appropriate deadline.

(i) For state fiscal year (SFY) 2006, the deadline for all CPE hospitals to submit the federally required Medicaid cost report schedules is June 30, 2007.

(ii) For hospitals with a December 31 year end, partial year Medicaid cost report schedules for the period July 1, 2005 through December 31, 2005 must be submitted to the department by August 31, 2007.

(iii) For SFY 2007 and thereafter, each CPE hospital is required to submit the Medicaid cost report schedules to the department within thirty days after the Medicare cost report is due to its Medicare fiscal intermediary.

(b) Complete the cost report schedules for Medicaid MCO plan and the uninsured patients using the hospital provider's records.

(c) Comply with the department's instructions regarding how to complete the required cost report schedules.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5410, filed 6/29/07, effective 8/1/07.]

WAC 388-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. (1) The upper pay-

ment limit (UPL) program is terminated effective July 1, 2007. The department will not make UPL payments after June 30, 2007.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5425, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5425, filed 3/30/06, effective 4/30/06.]

WAC 388-550-5450 Supplemental distributions to approved trauma service centers. (1) The trauma care fund (TCF) is an amount legislatively appropriated to the department each biennium, at the legislature's sole discretion, for the purpose of supplementing the department's payments to eligible trauma service centers for providing qualified trauma services to eligible Medicaid fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for supplemental distributions from the TCF.

(2) Beginning with trauma services provided after June 30, 2003, the department makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section and subject to legislative action.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable WAC;

(c) Meet the billing requirements in this section and other applicable WAC;

(d) Submit all information the department requires to ensure services are being provided; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) Allocated into five fixed payment pools of equal amounts. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals are determined by first summing each eligible hospital's qualifying payments since the beginning of the service year and expressing this amount as a percentage of total payments to all eligible hospitals for qualifying services provided during the service year to date. Each hospital's payment percentage is multiplied by the available amount in the current period pool to determine the portion of the pool to be paid to each qualifying hospital. Eligible hospitals and qualifying payments are described in (i) through (iii) of this subsection:

(i) Qualifying payments are the department's payments to Level 1, Level 2, and Level 3 trauma service centers for qualified Medicaid trauma cases since the beginning of the service year. The department determines the countable payment for trauma care provided to Medicaid clients based on date of service, not date of payment;

(ii) The department's payments to Level 1, Level 2, and Level 3 hospitals for trauma cases transferred in since the beginning of the service year. A Level 1, Level 2, or Level 3 hospital that receives a transferred trauma case from any lower level hospital is eligible for the enhanced payment, regardless of the client's injury severity score (ISS). An ISS is a summary rating system for traumatic anatomic injuries; and

(iii) The department's payments to Level 2 and Level 3 hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in subsection (4)(b) of this section) that these hospitals transferred to a higher level designated trauma service center since the beginning of the service year.

(b) Paid only for a Medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of subsection (4)(c).

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) It is designated or recognized by DOH as an approved Level 2 or Level 3 adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (b)(ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level 4 or Level 5 trauma service center does not qualify for supplemental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in subsection (4)(b) of this section.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the department to:

(i) Trauma service centers designated or recognized as Level 4 or Level 5;

(ii) Critical access hospitals (CAHs), except when the CAH is also a Level 3 trauma service center. Beginning with qualifying trauma services provided in state fiscal year (SFY) 2007, the department allows a hospital with this dual status to receive distributions from the TCF; or

(iii) Any hospital for follow-up surgical services related to the qualifying trauma incident but provided to the client after the client has been discharged for the initial qualifying injury.

(5) Distributions for an SFY are divided into five "quarters" and paid as follows:

(a) Each quarterly distribution paid by the department from the TCF totals twenty percent of the amount designated by the department for that SFY;

(b) The first quarterly supplemental distribution from the TCF is made six months after the SFY begins;

(c) Subsequent quarterly payments are made approximately every four months after the first quarterly payment is made, except as described in subsection (d);

(d) The "fifth quarter" final distribution from the TCF for the same SFY is:

(i) Made one year after the end of the SFY;

(ii) Based on the SFY that the TCF designated amount relates to; and

(iii) Distributed based on each eligible hospital's percentage of the total payments made by the department to all des-

ignated trauma service centers for qualified trauma cases during the relevant fiscal year.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) The department may consider a request for a claim adjustment submitted by a provider only if the request is received by the department within one year from the date of the initial trauma service;

(b) The department does not allow any carryover of liabilities for a supplemental distribution from the TCF beyond three hundred sixty-five calendar days from the date of discharge (inpatient) or date of service (outpatient). The deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the department. WAC 388-502-0150(7) does not apply to TCF claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the department in any biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-14-090, § 388-550-5450, filed 6/29/07, effective 8/1/07; 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]

WAC 388-550-6000 Outpatient hospital services—Conditions of payment and payment methods. (1) The department pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 388-550-1700. All professional medical services must be billed according to chapter 388-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

(a) Have a current core provider agreement with the department;

(b) Bill the department according to the conditions of payment under WAC 388-502-0100;

(c) Bill the department according to the time limits under WAC 388-502-0150; and

(d) Meet program requirements in other applicable WAC and the department's published issuances.

(3) The department does not pay separately for any services:

(a) Included in a hospital's room charges;

(b) Included as covered under the department's definition of room and board (e.g., nursing services). See WAC 388-550-1050; or

(c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.

(4) The department does not pay:

(a) A hospital for outpatient hospital services when a managed care plan is contracted with the department to cover these services;

(b) More than the "acquisition cost" ("A.C.") for HCPCS (healthcare common procedure coding system) codes noted in the outpatient fee schedule; or

(c) For cast room, emergency room, labor room, observation room, treatment room, and other room charges in combination when billing periods for these charges overlap.

(5) The department uses the outpatient departmental weighted costs-to-charges (ODWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 388-550-2598.

(6) The department uses the maximum allowable fee schedule to pay non-OPPS hospitals and non-CAH hospitals for the following types of covered outpatient hospital services listed in the department's current published outpatient hospital fee schedule and billing instructions:

- (a) EKG/ECG/EEG and other diagnostics;
- (b) Imaging services;
- (c) Immunizations;
- (d) Laboratory services;
- (e) Occupational therapy;
- (f) Physical therapy;
- (g) Sleep studies;
- (h) Speech/language therapy;
- (i) Synagis; and
- (j) Other hospital services identified and published by the department.

(7) The department uses the hospital outpatient rate as described in WAC 388-550-4500 to pay for covered outpatient hospital services when:

- (a) A hospital provider is a non-OPPS or a non-CAH provider; and
- (b) The services are not included in subsection (6) of this section.

(8) Hospitals must provide documentation as required and/or requested by the department.

(9) All hospital providers must present final charges to the department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-6000, filed 6/20/07, effective 8/1/07; 04-20-060, § 388-550-6000, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-044, § 388-550-6000, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09-500, 74.09.035(1), and 43.88.290, 02-21-019, § 388-550-6000, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x (v), 42 C.F.R. 447.271 and 42 C.F.R. 11303, 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department pays for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department pays for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the the department as centers of excellence for sleep apnea/sleep study programs.

(3) The department does not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals must bill the department for sleep studies using current procedural terminology codes. The department does not pay hospitals for these services when billed under revenue codes alone.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-6350, filed 6/20/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6500 Blood and blood components. (1)

The department pays a hospital only for:

- (a) Blood bank service charges for processing and storage of blood and blood components; and
- (b) Blood administration charges.

(2) The department does not pay for blood and blood components.

(3) The department does not pay a hospital separately for the services identified in subsection (1) when these services are included and paid using the diagnosis-related group (DRG), per diem, or per case rate payment rates.

(4) The department pays a hospital no more than the hospital's cost, as determined by the department, for the services identified in subsection (1) when the hospital is paid using the ratio of costs-to-charges (RCC) or departmental weighted costs-to-charges (DWCC) payment method.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-6500, filed 6/20/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6700 Hospital services provided out-of-state. (1) The department pays:

(a) For dates of admission before August 1, 2007 for only emergency care for an eligible Medicaid and SCHIP client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(b) For dates of admission on and after August 1, 2007, for both emergency and nonemergency out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, for eligible Medicaid and SCHIP clients based on the medical necessity and utilization review standards and limits established by the department.

(i) Prior authorization by the department is required for the nonemergency out-of-state hospital medical care provided to Medicaid and SCHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As in-state hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. Department designated critical border hospitals are paid as in-state hospitals. See WAC 388-550-3900 and 388-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible Medicaid and SCHIP clients based on authorization by a mental health division designee.

(d) Based on the department's limitations on hospital coverage under WAC 388-550-1100 and 388-550-1200 and other applicable rules.

(2) The department authorizes and pays for comparable hospital services for a Medicaid and SCHIP client who is temporarily outside the state to the same extent that such services are furnished to an eligible Medicaid client in the state, subject to the exceptions and limitations in this section. See WAC 388-550-3900 and 388-550-4000.

(3) The department limits out-of-state hospital coverage for clients eligible under state-administered programs as follows:

(a) For a client eligible under the psychiatric indigent inpatient (PII) program or who receives services under the Involuntary Treatment Act (ITA), the department does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(b) For a client eligible under a department's general assistance program, the department pays only for hospital services covered under the client's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The department does not pay for hospital services provided to clients eligible under a general assistance program in other hospitals located outside the state of Washington. The department or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC 388-550-1200.

(4) The department covers hospital care provided to Medicaid or SCHIP clients in areas of Canada as described in WAC 388-501-0180, and based on the limitations described in the state plan.

(5) The department may review all cases involving out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, to determine whether the services are within the scope of the client's medical assistance program.

(6) If the client can claim deductible or coinsurance portions of Medicare, the provider must submit the claim to the intermediary or carrier in the provider's own state on the appropriate Medicare billing form. If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For payment for out-of-state inpatient hospital services, see WAC 388-550-3900 and 388-550-4000.

(8) Out-of-state providers, including bordering city hospitals and critical border hospitals, must present final charges to the department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment of charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

[Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-6700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090. 01-02-075, § 388-550-6700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-7000 Outpatient prospective payment system (OPPS)—General. (1) The department's outpatient

prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement methodology as its primary reimbursement method. The department is basing its OPPS on the centers for Medicare and Medicaid services (CMS) prospective payment system for hospital outpatient department services.

(2) For a complete description of the CMS outpatient hospital prospective payment system, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419. The Code of Federal Regulations (CFR) is available from the CFR web site and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

[Statutory Authority: RCW 74.08.090, 74.09.500. 07-13-100, § 388-550-7000, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7000, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7050 OPPS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the department's outpatient prospective payment system (OPPS):

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Budget target" means the amount of money appropriated by the legislature or through the department's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means the department specific multiplier applied to all payable ambulatory payment classifications (APCs) to allow the department to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National payment rate" means a rate for a given procedure code, published by the centers for Medicare and Medicaid (CMS), that does not include a state or location specific adjustment.

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program published by 3M Health Information Systems that the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPSS.

"Outpatient prospective payment system (OPSS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system conversion factor" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for Medicare and Medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a one-digit identifier assigned to each service by the outpatient code editor (OCE) software.

"SI" see **"status indicator."**

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7050, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7100 OPSS—Exempt hospitals. The department exempts the following hospitals from the initial implementation of department's outpatient prospective payment system (OPSS). (Refer to other sections in chapter 388-550 WAC for outpatient payment methods the department uses to pay hospital providers that are exempt from the department's OPSS.)

- (1) Cancer hospitals;
- (2) Critical access hospitals;
- (3) Free-standing psychiatric hospitals;
- (4) Pediatric hospitals;
- (5) Peer group A hospitals;
- (6) Rehabilitation hospitals; and
- (7) Veterans' and military hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7100, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7200 OPSS—Payment method. (1) This section describes the payment methods the department uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPSS).

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(2) The department uses the APC method when the centers for Medicare and Medicaid services (CMS) has established a national payment rate to pay for covered services. The APC method is the primary payment methodology for OPSS. Examples of services paid by the APC methodology include, but are not limited to:

- (a) Ancillary services;

- (b) Medical visits;
- (c) Nonpass-through drugs or devices;
- (d) Observation services;
- (e) Packaged services subject to separate payment when criteria are met;
- (f) Pass-through drugs;
- (g) Significant procedures that are not subject to multiple procedure discounting (except for dental-related services);
- (h) Significant procedures that are subject to multiple procedure discounting; and
- (i) Other services as identified by the department.

OPSS MAXIMUM ALLOWABLE FEE SCHEDULE

(3) The department uses the outpatient fee schedule published in the department's billing instructions to pay for covered:

- (a) Services that are exempted from the APC payment methodology or services for which there are no established weight(s);
- (b) Procedures that are on the CMS inpatient only list;
- (c) Items, codes, and services that are not covered by Medicare;
- (d) Corneal tissue acquisition;
- (e) Devices that are pass-throughs (see WAC 388-550-7050 for definition of pass-throughs); and
- (f) Dental clinic services.

HOSPITAL OUTPATIENT RATE

(4) The department uses the hospital outpatient rate described in WAC 388-550-3900 and 388-550-4500 to pay for the services listed in subsection (3) of this section for which the department has not established a maximum allowable fee.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7200, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7300 OPSS—Payment limitations. (1)

The department limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient fee schedule and published in the department's hospital billing instructions, subject to the following:

(a) When a unit limit for services is not stated in the outpatient fee schedule, department pays for services according to the program's unit limits stated in applicable WAC and published issuances.

(b) Because multiple units for services may be factored into the ambulatory payment classification (APC) weight, department pays for services according to the unit limit stated in the outpatient fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published issuances.

(2) The department does not pay separately for covered services that are packaged into the APC rates. These services are paid through the APC rates.

(3) The department:

- (a) Limits surgical dental services payment to the ambulatory surgical services fee schedule and pays:
 - (i) The first surgical procedure at the applicable ambulatory surgery center group rate; and

(ii) The second surgical procedure at fifty percent of the ambulatory surgery center group rate.

(b) Considers all surgical procedures not identified in subsection (a) to be bundled.

(4) The department limits outpatient services billing to one claim per episode of care. If there are late charges, or if any line of the claim is denied, the department requires the entire claim to be adjusted.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7300, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7400 OPSS APC relative weights. The department uses the ambulatory payment classification (APC) relative weights established by the centers for Medicare and Medicaid services (CMS) at the time the budget target adjuster is established. See WAC 388-550-7050 for the definition of budget target adjuster.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7400, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7400, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7500 OPSS conversion factor. The department calculates the outpatient prospective payment system (OPSS) conversion factors by modeling, using the centers for Medicare and Medicaid services (CMS) addendum B and wage index information available and published at the time the OPSS conversion factors are set for the upcoming year.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7600 OPSS payment calculation. (1) The department follows the discounting and modifier policies of the centers for Medicare and Medicaid services (CMS). The department calculates the ambulatory payment classification (APC) payment as follows:

APC payment =
National payment rate x Hospital OPSS conversion factor x
Discount factor (if applicable) x Units of service (if applicable) x
Budget target adjuster

(2) The total OPSS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

(3) The department pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

(a) Billed amount minus the third-party payment amount; or

(b) Allowed amount minus the third-party payment amount.

[Statutory Authority: RCW 74.08.090, 74.09.500, 07-13-100, § 388-550-7600, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]

Chapter 388-557 WAC CHRONIC CARE MANAGEMENT

WAC

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| 388-557-0050 | Chronic care management program—General. |
| 388-557-0100 | Chronic care management program—Definitions. |
| 388-557-0200 | Chronic care management program—Client eligibility and participation. |
| 388-557-0300 | Chronic care management program services—Confidentiality and data sharing. |
| 388-557-0400 | Chronic care management program services—Payment. |

WAC 388-557-0050 Chronic care management program—General. (1) The department's chronic care management program:

(a) Offers care management and coordination activities for medical assistance clients determined to be at risk for high medical costs;

(b) Provides education, training, and/or coordination of services for program participants through statewide care management (SCM) and local care management (LCM) providers contracted with DSHS;

(c) Assists program participants in improving self-management skills and improving health outcomes; and

(d) Reduces medical costs by educating clients to better utilize healthcare services.

(2) The department's chronic care management program does not:

(a) Change the scope of services available to a client eligible under a Title XIX Medicaid program;

(b) Interfere with the relationship between a participant (client) and the client's chosen department-enrolled provider(s);

(c) Duplicate case management activities available to a client in the client's community; or

(d) Substitute for established activities that are available to a client and provided by programs administered through other DSHS divisions or state agencies.

(3) Chronic care management program services provided by a statewide care management (SCM) contractor and a local care management (LCM) contractor must meet:

(a) The conditions of the contract between DSHS and the contractor; and

(b) Applicable state and federal requirements.

(4) The SCM contractor uses a predictive modeling program to review DSHS claims, and eligibility data to identify clients eligible to participate in the chronic care management program.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. 07-20-048, § 388-557-0050, filed 9/26/07, effective 11/1/07.]

WAC 388-557-0100 Chronic care management program—Definitions. The following terms and definitions apply to the chronic care management program:

"Chronic care management program services" are services provided by DSHS-contracted organizations to clients with multiple health, behavioral, and social needs in order to improve care coordination, client education, and client self-management skills.

"Evidence-based healthcare practice" means a clinical approach to practicing medicine based on the clinician's awareness of evidence and the strength of that evidence to support the management of a disease treatment process.

"Local care management program" or "LCM program" means a comprehensive care management program and medical home program for medical assistance clients (participants) that serves a specific geographical area of the state.

"Local care management (LCM) contractor" means an entity or group of entities that contracts with DSHS to provide chronic care management program services to eligible participants (clients).

"Medical home" means an approach to providing healthcare services in a high-quality and cost-effective manner that is accessible, family-centered, comprehensive, continuous, coordinated, compassionate, and culturally competent.

"Participant" means a medical assistance client who has been contacted by an SCM or LCM, and has agreed to participate in the chronic care management program.

"Predictive modeling" means using historical medical claims data to predict future utilization of medical services.

"Self-management" means, with guidance from a healthcare team, the concept of a medical assistance client being the "driver" of their own healthcare to improve their healthcare outcome through:

- Education;
- Monitoring;
- Adherence to evidence-based guidelines; and
- Active involvement in the decision-making process with the team.

"Statewide care management program" or "SCM program" means a comprehensive care management program for clients that serves all areas of the state not served by a local care management (LCM) program.

"Statewide care management (SCM) contractor" means an entity that contracts with DSHS to provide chronic care management program services to eligible medical assistance clients (participants). The SCM contractor provides client identification and referral to appropriate local care management (LCM) programs through predictive modeling.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. 07-20-048, § 388-557-0100, filed 9/26/07, effective 11/1/07.]

WAC 388-557-0200 Chronic care management program—Client eligibility and participation. (1) To be a participant in the chronic care management program, a client must:

(a) Be a recipient of the Supplemental Security Income (SSI) program or general assistance with expedited medical categorically needy (GAX) program;

(b) Be identified through predictive modeling as being high risk for high medical costs as a result of needing medical treatment for multiple conditions; and

(c) Agree to participate in the program.

(2) A client participating in the chronic care management program must not be:

(a) Receiving medicare benefits;

(b) Residing in an institution, as defined in WAC 388-500-0005, for more than thirty days;

(c) Eligible for third party coverage that provides care management services or requires administrative controls that would duplicate or interfere with the department's chronic care management program;

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(d) Enrolled with a managed care organization (MCO) plan contracted with DSHS;

(e) Currently receiving long term care services; or

(f) Receiving case management services that chronic care management program services would duplicate.

(3) Using data provided by DSHS, the statewide care management (SCM) contractor identifies medical assistance clients who are potential participants for chronic care management program services. A client who meets the participation requirements in this section:

(a) Will be served by the SCM program or a local care management (LCM) program, based on the geographical area of the state the client resides.

(b) Will be contacted by an SCM or LCM care manager for an assessment and enrollment in the program;

(c) Will not be enrolled unless the client specifically agrees to the enrollment;

(d) May request disenrollment at any time. Disenrollment is effective the first day of the following month; and

(e) May request reenrollment at any time. Reenrollment is effective the first day of the following month.

(4) A participating client who subsequently enrolls in a DSHS voluntary managed care program is no longer eligible for chronic care management program services.

(5) A client who meets the eligibility and enrollment criteria for participation in the chronic care management services program:

(a) Is eligible to participate for six months from the date of enrollment provided the client continues to meet eligibility and enrollment criteria; and

(b) May participate for additional six-month participation periods if both the department and the SCM or LCM contractor determine that the participant's self-management skills and healthcare outcome would benefit.

(6) A client who does not agree with a decision regarding chronic care management program services has a right to a hearing under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. 07-20-048, § 388-557-0200, filed 9/26/07, effective 11/1/07.]

WAC 388-557-0300 Chronic care management program services—Confidentiality and data sharing. (1) Statewide care management (SCM) and local care management (LCM) contractors must meet the confidentiality and data sharing requirements that apply to clients eligible under Title XIX Medicaid programs and as specified in the chronic care management contract.

(2) DSHS shares healthcare data with SCM and LCM contractors under the provisions of RCW 70.02.050 and the health insurance portability and accountability act of 1996 (HIPAA).

(3) DSHS requires SCM and LCM contractors to monitor and evaluate participant activities and provide to the department:

(a) Any client information collected; and

(b) Any data compiled as the result of the program.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. 07-20-048, § 388-557-0300, filed 9/26/07, effective 11/1/07.]

WAC 388-557-0400 Chronic care management program services—Payment. Only a DSHS-contracted state-

wide care management (SCM) and local care management (LCM) program may bill and be paid for providing the chronic care management program services described in chapter 388-557 WAC. Billing requirements and payment methodology are described in the contract between DSHS and the contractor.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, and 2007 c 259, § 4. 07-20-048, § 388-557-0400, filed 9/26/07, effective 11/1/07.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

| | |
|----------------------------|--|
| 388-825-150 | When can the department proceed to take action during my appeal? |
| 388-825-305 | What service providers are governed by the qualifications in these rules? |
| 388-825-320 388-825-325 | How does a person become an individual provider? What are required skills and abilities for individuals and agencies contracted to provide respite care, personal care services through the Medicaid personal care program or the DDD HCBS Basic, Basic Plus or CORE waivers, or attendant care services? |
| 388-825-340 | What is required for a provider to provide respite or residential service in their home? |
| 388-825-355 | Are there any educational requirements for individuals providing respite care, attendant care, or personal care services? |
| 388-825-370 | What are the responsibilities of an individual or home care agency when employed to provide respite care, attendant care, or personal care services to a client? |
| 388-825-375 | When will the department deny payment for services of an individual or home care agency providing respite care, attendant care, or personal care services? |
| 388-825-385 | When can the department terminate or summarily suspend an individual respite care, attendant care, or personal care provider's contract? |
| 388-825-390 | When can the department otherwise terminate an individual's contract to provide respite care, attendant care, or personal care? |
| 388-825-395 | What are the client's rights if the department denies, terminates, or summarily suspends an individual's contract to provide respite care, attendant care, or personal care? |
| 388-825-396 | Does the provider of respite care, attendant care, or personal care have a right to a fair hearing? |

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

| | |
|-------------|---|
| 388-825-316 | How do I choose a companion home or alternative living provider? [Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-316, filed 8/19/05, effective 9/19/05.] Repealed by 07-23-062, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. |
| 388-825-381 | When can the department reject the client's choice of a companion home services or alternative living services provider? [Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-381, filed 8/19/05, effective 9/19/05.] Repealed by 07-23-062, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. |

WAC 388-825-150 When can the department proceed to take action during my appeal? The department will proceed to take action during your appeal if:

- (1) It is an eligibility denial and you are not currently an eligible client.
- (2) Your DDD eligibility has expired, per WAC 388-823-0010 and 388-823-1040.

(3) There is no longer funding for state-only funded service.

(4) Your current services are terminated or transferred in order to meet the legislative intent of and comply with sections 205 and 207, chapter 371, Laws of 2002.

(5) The state-only funded service no longer exists, the Medicaid state plan has been amended, or the HCBS waiver agreement with the federal Centers for Medicare and Medicaid has been amended.

(6) The administrative law judge or review judge rules that you have caused unreasonable delay in the proceedings.

(7) You are in imminent jeopardy.

(8) Your provider is no longer qualified to provide services due to:

- (a) A lack of a contract;
- (b) Decertification;
- (c) Revocation or suspension of a license; or
- (d) Lack of required registration, certification, or licensure.

(9) The parent of a person under the age of eighteen or the legal guardian approves the department's decision.

(10) You did not file your request for an administrative hearing within the ten-day notice period, as described in chapter 388-458 WAC.

(11) You:

- (a) Tell us in writing that you do not want continued benefits;
- (b) Withdraw your administrative hearing request in writing; or
- (c) Do not follow through with the administrative hearing process.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-06-055, § 388-825-150, filed 3/5/07, effective 4/5/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-150, filed 8/19/05, effective 9/19/05.]

WAC 388-825-305 What service providers are governed by the qualifications in these rules? These rules govern individuals and agencies contracted with to provide:

- (1) Respite care services;
- (2) Personal care services through the Medicaid personal care program or DDD HCBS Basic, Basic Plus, or CORE waivers; or
- (3) Attendant care services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-305, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-305, filed 8/19/05, effective 9/19/05.]

WAC 388-825-320 How does a person become an individual provider? In order to become an individual provider, a person must:

- (1) Be eighteen years of age or older.
- (2) Provide the social worker/case manager/designee with:
 - (a) Picture identification; and
 - (b) A Social Security card.
- (3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application, unless the provider is also the

parent of the adult DDD client and exempted, per chapter 74.15 RCW.

(a) Preliminary results may require a thumbprint for identification purposes.

(b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.

(4) Provide references as requested.

(5) Complete orientation, if contracting as an individual provider.

(6) Sign a service provider contract to provide services to a DDD client.

(7) Meet additional requirements in WAC 388-825-355.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-320, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-320, filed 8/19/05, effective 9/19/05.]

WAC 388-825-325 What are required skills and abilities for individuals and agencies contracted to provide respite care, personal care services through the Medicaid personal care program or the DDD HCBS Basic, Basic Plus or CORE waivers, or attendant care services? (1) As a provider of respite care, personal care services through the Medicaid personal care program or the DDD HCBS Basic, Basic Plus, or CORE waivers, or attendant care services, you must be able to:

(a) Adequately maintain records of services performed and payments received;

(b) Read and understand the person's service plan. Translation services may be used if needed;

(c) Be kind and caring to the DSHS client for whom services are authorized;

(d) Identify problem situations and take the necessary action;

(e) Respond to emergencies without direct supervision;

(f) Understand the way your employer wants you to do things and carry out instructions;

(g) Work independently;

(h) Be dependable and responsible;

(i) Know when and how to contact the client's representative and the client's case resource manager;

(j) Participate in any quality assurance reviews required by DSHS;

(2) If you are working with an adult client of DSHS as a provider of attendant care, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-325, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-325, filed 8/19/05, effective 9/19/05.]

WAC 388-825-340 What is required for a provider to provide respite or residential service in their home?

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Unless you are related to the client, respite or residential services must take place in a home licensed by DSHS. Services are limited to those age-specific services contained in your license.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-340, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-340, filed 8/19/05, effective 9/19/05.]

WAC 388-825-355 Are there any educational requirements for individuals providing respite care, attendant care, or personal care services? (1) If you are an individual providing personal care services for adults, you must meet the training requirements in WAC 388-71-05665 through 388-71-05909.

(2) If you provide personal care for children, or provide respite care, there is no required training but DDD retains the authority to require training of any provider.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-355, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-355, filed 8/19/05, effective 9/19/05.]

WAC 388-825-370 What are the responsibilities of an individual or home care agency when employed to provide respite care, attendant care, or personal care services to a client? An individual or home care agency employed to provide respite care, attendant care, or personal care services must:

(1) Understand the client's individual service plan or plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;

(2) Provide the services as outlined on the client's service plan, within the scope of practice in WAC 388-71-0215 and 388-71-0230;

(3) Accommodate client's individual preferences and differences in providing care, within the scope of the service plan;

(4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the service plan;

(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;

(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

(7) Notify the case manager immediately if the client dies;

(8) Notify the department immediately when unable to staff/serve the client; and

(9) Notify the department when the individual or home care agency will no longer provide services. Notification to the client/legal guardian must:

(a) Give at least two weeks' notice, and

(b) Be in writing.

(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and

(11) Comply with all applicable laws, regulations and contract requirements.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-370, filed 11/16/07, effective 12/17/07. Statutory

Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-370, filed 8/19/05, effective 9/19/05.]

WAC 388-825-375 When will the department deny payment for services of an individual or home care agency providing respite care, attendant care, or personal care services? (1) The department will deny payment for the services of an individual or home care agency providing respite care, attendant care, or personal care who:

(a) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(b) Is providing services under this chapter to their natural/step/adoptive minor client aged seventeen or younger;

(c) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(d) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(e) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(f) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05909; or

(g) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

(2) In addition, the department may deny payment to or terminate the contract of an individual provider as provided under WAC 388-825-380, 388-825-381, 388-825-385 and 388-825-390.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-375, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-375, filed 8/19/05, effective 9/19/05.]

WAC 388-825-385 When can the department terminate or summarily suspend an individual respite care, attendant care, or personal care provider's contract? The department may take action to terminate an individual respite care, attendant care, or personal care provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the client's health, safety, or well-being. The department may summarily or immediately suspend the contract pending a hearing based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies; and/or

(7) Failure to respond appropriately to emergencies.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-385, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-385, filed 8/19/05, effective 9/19/05.]

WAC 388-825-390 When can the department otherwise terminate an individual's contract to provide respite care, attendant care, or personal care? The department may otherwise terminate the individual's contract to provide respite care, attendant care, or personal care for default or convenience in accordance with the terms of the contract and to the extent that those terms are not inconsistent with these rules.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-390, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-390, filed 8/19/05, effective 9/19/05.]

WAC 388-825-395 What are the client's rights if the department denies, terminates, or summarily suspends an individual's contract to provide respite care, attendant care, or personal care? If the department denies, terminates, or summarily (immediately) suspends the individual's contract to provide respite care, attendant care, or personal care, the client has the right to:

(1) A fair hearing to appeal the decision, per chapter 388-02 WAC and WAC 388-825-120; and

(2) Receive services from another currently contracted individual or home care agency, or other options the client is eligible for, if a contract is summarily suspended.

(3) The hearing rights afforded under this section are those of the client, not the individual provider.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-395, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-395, filed 8/19/05, effective 9/19/05.]

WAC 388-825-396 Does the provider of respite care, attendant care, or personal care have a right to a fair hearing? (1) The hearing rights afforded under WAC 388-825-395(1) are those of the client.

(2) The provider of respite care, attendant care, or personal care services does not have a right to a fair hearing.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-23-062, § 388-825-396, filed 11/16/07, effective 12/17/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-396, filed 8/19/05, effective 9/19/05.]

Chapter 388-826 WAC

VOLUNTARY PLACEMENT PROGRAM

WAC

388-826-0085

What other DDD services are available for a child through the voluntary placement program?

- 388-826-0129 What are the residential settings that DDD uses to provide voluntary placement program services?
- 388-826-0130 How does DDD determine the rate that is paid to support a child in a licensed foster home?
- 388-826-0135 When does DDD administer the foster care rate assessment tool?
- 388-826-0136 How often does DDD administer the foster care rate assessment tool?
- 388-826-0138 What questions are asked in the foster care rate assessment tool and how are the licensed foster home provider's answers scored?
- 388-826-0145 How does DDD determine the foster care level from the raw score?
- 388-826-0175 How does DDD determine the rate that is paid to support a child in a licensed group care facility?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-826-0140 What areas are covered in the foster care assessment? [Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0140, filed 1/31/06, effective 3/2/06.] Repealed by 07-15-003, filed 7/6/07, effective 8/6/07. Statutory Authority: RCW 74.13.750.

WAC 388-826-0085 What other DDD services are available for a child through the voluntary placement program? (1) When a parent signs a voluntary placement agreement and the child is placed outside the parental home, the child will no longer be eligible for services from the state-funded family support program.

(2) Children living with their parents may receive personal care services provided under chapter 388-71 WAC.

(3) If the child is covered under the DDD core waiver as described in chapter 388-845 WAC, the child will receive the services identified on the plan of care.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0085, filed 7/6/07, effective 8/6/07. Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0085, filed 1/31/06, effective 3/3/06. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0085, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0129 What are the residential settings that DDD uses to provide voluntary placement program services? DDD voluntary placement program services may be provided in a:

- (1) Licensed foster home;
- (2) Licensed group care facility;
- (3) Licensed staffed residential home; or
- (4) Licensed child placing agency.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0129, filed 7/6/07, effective 8/6/07.]

WAC 388-826-0130 How does DDD determine the rate that is paid to support a child in a licensed foster home? DDD determines the rate that is paid to support a child in a licensed foster home by adding:

- (1) The basic foster care room and board rate published annually by children's administration per WAC 388-25-0120.
- (2) The specialized rate identified after administering the foster care rate assessment (FCRA) tool.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0130, filed 7/6/07, effective 8/6/07. Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0130, filed 1/31/06, effective 3/3/06.]

WAC 388-826-0135 When does DDD administer the foster care rate assessment tool? DDD administers the foster care rate assessment tool within thirty days from the date of the child's admission to a licensed foster home.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0135, filed 7/6/07, effective 8/6/07.]

WAC 388-826-0136 How often does DDD administer the foster care rate assessment tool? (1) DDD administers the foster care rate assessment tool on an annual basis, between the months of November and February so rates can be updated by April 1 of each year.

(2) DDD does not have to readminister the foster care rate assessment if it was administered within ninety days of February 1.

(3) The FCRA may be readministered if a significant change is reported that affects the child's need for support (e.g., changes in medical condition, behavior, caregiver status, etc.).

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0136, filed 7/6/07, effective 8/6/07.]

WAC 388-826-0138 What questions are asked in the foster care rate assessment tool and how are the licensed foster home provider's answers scored? The foster care rate assessment tool consists of thirteen questions that are scored by DDD based on discussion between the DSHS representative and the licensed foster home provider.

(1) Daily living: Include the average number of hours per day spent caring for this child beyond what is expected for his/her age on daily living tasks including dressing, grooming, toileting, feeding and providing specialized body care.

| Answers | Score |
|----------|-------|
| 0 to 1 | 30 |
| 2 to 5 | 91 |
| 6 to 9 | 213 |
| 10 to 20 | 396 |
| Over 20 | 609 |

(2) Physical needs: What is the average number of hours per day beyond what is expected for his/her age providing assistance not included in the "daily living" category above? (E.g., wheelchairs, prosthetics, and other assistive devices, dental/orthodontic, communication (speech, hearing, sight), airway management (monitors, ventilators), pressure sores and/or intravenous nutrition).

| Answers | Score |
|---------|-------|
| 0 to 1 | 30 |
| 2 to 5 | 91 |
| 6 to 20 | 274 |
| Over 20 | 609 |

(3) Behavioral needs: What is the average number of hours per day the foster parent(s) will need to spend supporting and supervising the child due to behaviors disorders, emotional disorders, and mental disorders?

| Answers | Score |
|---------|-------|
| 0 to 1 | 30 |
| 2 to 5 | 91 |

| | |
|----------|-----|
| 6 to 13 | 335 |
| 14 to 24 | 578 |
| Over 24 | 731 |

(4) Participation in child's therapeutic plan: Include the average number of hours per week implementing a plan prescribed by a professional related to the child's physical, behavioral, emotional or mental therapy.

(a) Physical therapeutic plan (e.g., meeting with providers, attending therapy or directly giving physical, occupational or post-surgical therapy).

| Answers | Score |
|----------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 9 | 30 |
| 10 to 46 | 65 |

(b) Participation in emotional/behavioral support plan (e.g., meeting with providers, attending therapy or directly supporting therapeutic plan).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 19 | 48 |
| 20 to 60 | 104 |
| Over 60 hours/week | 390 |

(5) Arranging, scheduling and supervising activities: Indicate the average number of hours per week scheduling appointments and accompanying the child.

(a) Medical/dental (e.g., transporting and waiting for medical services including doctor visits, dental visits, rehabilitation, and therapy visits).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 5 | 13 |
| 6 to 14 | 39 |
| Over 14 hours/week | 82 |

(b) Community activities (e.g., transporting and waiting during events including recreation, leisure, sports or extracurricular activities).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 7 | 30 |
| 8 to 20 | 48 |
| Over 20 hours/week | 130 |

(6) House care: Indicate the average number of times per week to repair, clean or replace household items, including medical equipment, over and above normal wear and tear, due to:

(a) Chronic conditions (e.g., lack of personal control resulting in bed-wetting or incontinence, lack of muscle control or unawareness of the consequences of physical actions).

| Answers | Score |
|---------|-------|
| 0 to 1 | 6 |
| 2 to 7 | 24 |
| 8 to 19 | 58 |

| | |
|------------------------|-----|
| 20 to 38 | 91 |
| Over 38 times per week | 238 |

(b) Destructive behavior (e.g., lack of emotional control resulting in damage or destruction of property).

| Answers | Score |
|------------------------|-------|
| 0 to 1 | 6 |
| 2 to 3 | 15 |
| 4 to 9 | 28 |
| 10 to 22 | 58 |
| Over 22 times per week | 162 |

(7) Development and socialization: Indicate the average number of hours per week to provide guidance and assistance.

(a) Direct developmental assistance (e.g., helping with homework and readiness to learn activities).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 11 | 30 |
| 12 to 30 | 87 |
| Over 30 hours/week | 249 |

(b) Professional interaction (e.g., meeting with teachers, visiting the school either planned or in crisis, speaking on the phone with school personnel, participating in individual education plan development and review).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 5 | 22 |
| 6 to 12 | 30 |
| Over 12 hours/week | 82 |

(c) Socialization and functional life skills (e.g., helping the child build skills, make choices and take responsibility, learn about the use of money, relate to peers, adults and family members and explore the community).

| Answers | Score |
|--------------------|-------|
| 0 to 1 | 4 |
| 2 to 7 | 22 |
| 8 to 19 | 56 |
| 20 to 60 | 173 |
| Over 60 hours/week | 403 |

(8) Shared parenting: Indicate the average number of hours per week to work with the birth parents and/or siblings, including assisting in the care of the child during visits, demonstrating care techniques, planning and decision making.

| Answers | Score |
|---------|-------|
| 0 to 1 | 4 |
| 2 to 3 | 13 |
| 4 to 12 | 30 |
| Over 12 | 82 |

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0138, filed 7/6/07, effective 8/6/07.]

WAC 388-826-0145 How does DDD determine the foster care level from the raw score? The following are the foster care levels based on the range of aggregate scores:

| Level | Low Score | High Score |
|-------|-----------|------------|
| 1 | 0 | 320 |
| 2 | 321 | 616 |
| 3 | 617 | 1501 |
| 4 | 1502 | 2085 |
| 5 | 2086 | 2751 |
| 6 | 2752 | 999999 |

A standardized rate for specialized services is assigned to each level one through six. The standardized rate is published by DDD. The rate is paid monthly to the foster parent in addition to the basic rate.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0145, filed 7/6/07, effective 8/6/07.]

WAC 388-826-0175 How does DDD determine the rate that is paid to support a child in a licensed group care facility? A rate is negotiated by contract between DDD and the licensed group care facility.

[Statutory Authority: RCW 74.13.750. 07-15-003, § 388-826-0175, filed 7/6/07, effective 8/6/07.]

Chapter 388-827 WAC

STATE SUPPLEMENTARY PAYMENT PROGRAM

WAC

| | |
|--------------|---|
| 388-827-0110 | What are the financial eligibility requirements to receive DDD/SSP? |
| 388-827-0115 | What are the programmatic eligibility requirements for DDD/SSP? |
| 388-827-0121 | Will I need an assessment to remain eligible for SSP? |
| 388-827-0125 | How will I know if I am eligible to receive a DDD/SSP payment? |
| 388-827-0140 | What are my appeal rights if DDD determines that I am not eligible for DDD/SSP? |
| 388-827-0150 | How often will I receive my DDD/SSP warrant/check? |

WAC 388-827-0110 What are the financial eligibility requirements to receive DDD/SSP? Following are the financial eligibility requirements to receive DDD/SSP:

(1) You must be eligible for or receive supplemental security income (SSI) cash assistance in the month in which the DDD/SSP is issued; or

(2) You receive Social Security Title II benefits as a disabled adult child and you would be eligible for SSI if you did not receive these benefits.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0110, filed 11/28/07, effective 12/29/07. Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0110, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10-020, 2002 c 371. 04-02-015, § 388-827-0110, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0115 What are the programmatic eligibility requirements for DDD/SSP? Following are the programmatic eligibility requirements to receive DDD/SSP:

(1) You received one or more of the following services from DDD with state-only funding between March 1, 2001 and June 30, 2003 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services. Additionally, you must have been eligible for or

received SSI prior to July 1, 2006; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2006 and would have been eligible for SSI if you did not receive these benefits.

(a) Certain voluntary placement program services, which include:

- (i) Foster care basic maintenance,
- (ii) Foster care specialized support,
- (iii) Agency specialized support,
- (iv) Staffed residential home,
- (v) Out-of-home respite care,
- (vi) Agency in-home specialized support,
- (vii) Group care basic maintenance,
- (viii) Group care specialized support,
- (ix) Transportation,
- (x) Agency attendant care,
- (xi) Child care,
- (xii) Professional services,
- (xiii) Nursing services,
- (xiv) Interpreter services,

(b) Family support;

(c) One or more of the following residential services:

- (i) Adult family home,
- (ii) Adult residential care facility,
- (iii) Alternative living,
- (iv) Group home,
- (v) Supported living,
- (vi) Agency attendant care,
- (vii) Supported living or other residential service allowance,
- (viii) Intensive individual supported living support (companion homes).

(2) For individuals with community protection issues as defined in WAC 388-820-020, the department will determine eligibility for SSP on a case-by-case basis.

(3) For new authorizations of family support opportunity:

(a) You were on the family support opportunity waiting list prior to January 1, 2003; and

(b) You are on the home and community based services (HCBS) waiver administered by DDD; and

(c) You continue to meet the eligibility requirements for the family support opportunity program contained in WAC 388-825-200 through 388-825-242; and

(d) You must have been eligible for or received SSI prior to July 1, 2003; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2003 and would have been eligible for SSI if you did not receive these benefits.

(4) For individuals on one of the HCBS waivers administered by DDD (Basic, Basic Plus, Core or community protection):

(a) You must have been eligible for or received SSI prior to April 1, 2004; and

(b) You were determined eligible for SSP prior to April 1, 2004.

(5) You received Medicaid personal care (MPC) between September 2003 and August 2004; and

(a) You are under age eighteen at the time of your initial comprehensive assessment and reporting evaluation (CARE) assessment;

(b) You received or were eligible to receive SSI at the time of your initial CARE assessment;

(c) You are not on a home and community based services waiver administered by DDD; and

(d) You live with your family, as defined in WAC 388-825-020.

(6) If you meet all of the requirements listed in (5) above, your SSP will continue.

(7) You received one or more of the following state-only funded residential services between July 1, 2003 and June 30, 2006 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services:

- (a) Adult residential care facility;
- (b) Alternative living;
- (c) Group home;
- (d) Supported living;
- (e) Agency attendant care;
- (f) Supported living or other residential allowance.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0115, filed 11/28/07, effective 12/29/07. Statutory Authority: RCW 71A.12.030, 74.04.057 and 20 C.F.R. 416.2099. 06-24-074, § 388-827-0115, filed 12/4/06, effective 1/4/07. Statutory Authority: RCW 71A.12.030, 71A.12.120, and chapter 71A.12 RCW. 05-10-039, § 388-827-0115, filed 4/28/05, effective 5/29/05. Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0115, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0115, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0121 Will I need an assessment to remain eligible for SSP? DDD must administer a DDD assessment to you at least every twelve months to determine your eligibility to continue to receive SSP. The rules regarding the DDD assessment are contained in chapter 388-828 WAC.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0121, filed 11/28/07, effective 12/29/07.]

WAC 388-827-0125 How will I know if I am eligible to receive a DDD/SSP payment? You will receive a written notification from DDD if you have been identified as eligible for a DDD/SSP payment.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0125, filed 11/28/07, effective 12/29/07. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0125, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0140 What are my appeal rights if DDD determines that I am not eligible for DDD/SSP? You have the right to appeal the department's denial, termination, or reduction of your SSP. Your rights to an administrative hearing are contained in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-06-055, § 388-827-0140, filed 3/5/07, effective 4/5/07. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0140, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0150 How often will I receive my DDD/SSP warrant/check? You will receive a monthly DDD/SSP warrant/check from the state.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0150, filed 11/28/07, effective 12/29/07. Statutory Authority:

RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0150, filed 12/29/03, effective 1/29/04.]

Chapter 388-828 WAC

THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) ASSESSMENT

WAC

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|--------------|---|
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| 388-828-1540 | Who participates in your DDD assessment? |
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| | | | |
|--------------|--|--------------|---|
| 388-828-3000 | What is the purpose of the support assessment for children? | 388-828-5320 | How does DDD determine the availability of a backup caregiver? |
| 388-828-3020 | What is the purpose of the support assessment for children? | 388-828-5340 | How does DDD determine whether a backup caregiver lives with you? |
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| 388-828-3060 | How does DDD determine your total LOC score for ICF/MR level of care if you are age birth through fifteen years old? | 388-828-5380 | What is the DDD activities of daily living (ADL) acuity scale? |
| 388-828-3080 | How does DDD determine if you meet the eligibility requirements for ICF/MR level of care (LOC) if you are age birth through fifteen years old? | 388-828-5400 | What does the activities of daily living (ADL) acuity scale measure? |
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| 388-828-4020 | What is the purpose of the supports intensity scale (SIS) assessment? | 388-828-5440 | How does DDD use your ADL support needs score for the support assessment for children? |
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| 388-828-4080 | How does the SIS measure your support need(s) in the support needs and supplemental protection and advocacy scales? | 388-828-5500 | What is the DDD behavioral acuity scale? |
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| 388-828-4120 | How is frequency of support scored in the SIS assessment? | 388-828-5540 | How does DDD determine if you have a prominent behavior? |
| 388-828-4140 | How is daily support time scored in the SIS assessment? | 388-828-5560 | Do all prominent behaviors get scored? |
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| 388-828-4220 | What activities are assessed in the community living activities subscale of the support needs scale? | 388-828-5640 | How does DDD determine your behavioral acuity level? |
| 388-828-4240 | What activities are assessed in the lifelong learning activities subscale of the support needs scale? | 388-828-5660 | What is the DDD medical acuity scale? |
| 388-828-4260 | What activities are assessed in the employment activities subscale of the support needs scale? | 388-828-5680 | What is the purpose of the DDD medical acuity scale? |
| 388-828-4280 | What activities are assessed in the health and safety activities subscale of the support needs scale? | 388-828-5700 | How does DDD determine your medical acuity level? |
| 388-828-4300 | What activities are assessed in the social activities subscale of the support needs scale? | 388-828-5720 | What is the DDD interpersonal support acuity scale? |
| 388-828-4320 | What activities are assessed in the supplemental protection and advocacy activities subscale? | 388-828-5740 | What does the DDD interpersonal support acuity scale determine? |
| 388-828-4340 | How does DDD determine your support score for each of the items identified in the SIS exceptional medical and behavioral support needs scales? | 388-828-5760 | How does DDD determine your interpersonal support needs score if you are age birth through fifteen? |
| 388-828-4360 | What exceptional medical support activities are evaluated to assess your medical support needs? | 388-828-5780 | What does the DDD interpersonal support needs score determine if you are age birth through fifteen? |
| 388-828-4380 | What exceptional behavioral support activities are evaluated to assess your behavioral support needs? | 388-828-5800 | How does DDD determine your interpersonal support needs score if you are age sixteen or older? |
| 388-828-4400 | How does DDD determine if you meet the eligibility requirements for ICF/MR level of care if you are age sixteen or older? | 388-828-5820 | How does DDD use your interpersonal support needs score if you are age sixteen or older? |
| 388-828-4420 | How does DDD determine your percentile rank for each subscale in the SIS support needs scale? | 388-828-5840 | What is the DDD mobility acuity scale? |
| 388-828-5000 | What is the DDD protective supervision acuity scale? | 388-828-5860 | What does the DDD mobility acuity scale determine? |
| 388-828-5020 | How is information in the protective supervision acuity scale used by DDD? | 388-828-5880 | How does DDD determine your mobility acuity level if you are age birth through fifteen? |
| 388-828-5040 | What questions are asked in the DDD protective supervision acuity scale? | 388-828-5900 | How does DDD determine your mobility acuity level if you are age sixteen or older? |
| 388-828-5060 | How does DDD score each question? | 388-828-5920 | What is the respite assessment? |
| 388-828-5080 | How does DDD determine your adjusted protective supervision acuity score? | 388-828-5940 | Are there any exceptions when the respite assessment is not used to determine the number of hours for waiver respite services? |
| 388-828-5100 | How does DDD determine your protective supervision support level? | 388-828-5960 | What is the purpose of the respite assessment? |
| 388-828-5120 | What is the DDD caregiver status acuity scale? | 388-828-5980 | How does DDD determine your respite assessment level? |
| 388-828-5140 | How is information in the DDD caregiver status acuity scale used by DDD? | 388-828-6000 | How does DDD determine the maximum number of hours you may receive for respite care? |
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| 388-828-5180 | When is a collateral contact a formal caregiver? | 388-828-7000 | What is the purpose of the service level assessment module? |
| 388-828-5200 | When is a collateral contact a backup caregiver? | 388-828-7020 | What components contained in the service level assessment module determine a service level and/or number of hours? |
| 388-828-5220 | Are you allowed to identify more than one person as a backup caregiver? | 388-828-7040 | What is the DDD seizure acuity scale? |
| 388-828-5240 | Who is your primary caregiver? | 388-828-7060 | What does the DDD seizure acuity scale measure? |
| 388-828-5260 | What questions are asked in the DDD caregiver status acuity scale and how are your caregiver's answers scored? | 388-828-7080 | How does DDD determine your seizure acuity level? |
| 388-828-5280 | Which caregiver risk factors determine the caregiver risk level? | 388-828-8000 | What is the purpose of the individual support plan (ISP) module? |
| 388-828-5300 | How does DDD determine a caregiver risk level? | 388-828-8020 | What components contained in the individual support plan module determine a service level and/or number of hours? |
| | | 388-828-8040 | How does DDD determine which health and welfare needs must be addressed in your individual support plan if you are age birth through fifteen? |
| | | 388-828-8060 | How does DDD determine which health and welfare needs must be addressed in your individual support plan if you are age sixteen or older? |

WAC 388-828-1000 What is the purpose and scope of this chapter? This chapter establishes rules governing the administration of the division of developmental disabilities (DDD) assessment to persons determined eligible to be clients of the division per chapter 71A.16 RCW.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1020 What definitions apply to this chapter? The following definitions apply to this chapter:

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

"Acuity Scale" refers to an assessment tool that is intended to provide a framework for documenting important assessment elements and for standardizing the key questions that should be asked as part of a professional assessment. The design helps provide consistency from client to client by minimizing subjective bias and assists in promoting objective assessment of a person's support needs.

"ADSA" means the aging and disability services administration (ADSA), an administration within the department of social and health services, which includes the following divisions: Home and community services, residential care services, management services and division of developmental disabilities.

"ADSA contracted provider" means an individual or agency who is licensed, certified, and/or contracted by ADSA to provide services to DDD clients.

"Adult family home" or "AFH" means a residential home in which a person or persons provide personal care, special care, room and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services (see RCW 70.12.-010).

"Agency provider" means a licensed and/or ADSA certified business who is contracted with ADSA or a county to provide DDD services (e.g., personal care, respite care, residential services, therapy, nursing, employment, etc.).

"Algorithm" means a numerical formula used by the DDD assessment for one or more of the following:

- (1) Calculation of assessed information to identify a client's relative level of need;
- (2) Determination regarding which assessment modules a client receives as part of his/her DDD assessment; and
- (3) Assignment of a service level to support a client's assessed need.

"Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment for a service.

"CARE" refers to the comprehensive assessment reporting evaluation assessment per chapter 388-106 WAC.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Collateral contact" means a person or agency that is involved in the client's life (e.g., legal guardian, family member, care provider, friend, etc.).

"Companion home" is a DDD contracted residential service that provides twenty-four hour training, support, and supervision, to one adult living with a paid provider.

"DDD" means the division of developmental disabilities, a division with the aging and disability services administration (ADSA), department of social and health services (DSHS).

"Department" means the department of social and health services (DSHS).

"Group home" or "GH" means a ADSA licensed adult family home or boarding home contracted and certified by ADSA to provide residential services and support to adults with developmental disabilities.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded to provide habilitation services to DDD clients.

"ICF/MR level of care" is a standardized assessment of a client's need for ICF/MR level of care per 42 CFR 440 and 42 CFR 483. In addition, ICF/MR level of care refers to one of the standards used by DDD to determine whether a client meets minimum eligibility criteria for one of the DDD HCBS waivers.

"Individual support plan" or "ISP" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Legal guardian" means a person/agency, appointed by a court, who is authorized to make some or all decisions for a person determined by the court to be incapacitated. In the absence of court intervention, parents remain the legal guardians for their child until the child reaches the age of eighteen.

"LOC score" means a score for answers to questions in the support needs assessment for children that are used in determining if a client meets eligibility requirements for ICF/MR level of care.

"Modules" refers to three sections of the DDD assessment. They are: The support assessment, the service level assessment, and the individual support plan (ISP).

"Panel" refers to the visual user-interface in the DDD assessment computer application where assessment questions are typically organized by topic and you and your respondents' answers are recorded.

"Plan of care" or "POC" refers to the paper-based assessment and service plan for clients receiving services on one of the DDD HCBS waivers prior to June 1, 2007.

"Raw score" means the numerical value when adding a person's "Frequency of support," "Daily support time," and "Type of support" scores for each activity in the support needs and supplemental protection and advocacy scales of the supports intensity scale (SIS) assessment.

"Residential habilitation center" or "RHC" is a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities per chapter 71A.20 RCW.

"Respondent" means the adult client and/or another person familiar with the client who participates in the client's DDD assessment by answering questions and providing information. Respondents may include ADSA contracted providers.

"SIS" means the supports intensity scale developed by the American Association of Intellectual and Developmental Disabilities (AAIDD). The SIS is in the support assessment module of the DDD assessment.

"Service provider" refers to an ADSA contracted agency or person who provides services to DDD clients. Also refers to state operated living alternative programs (SOLA).

"SOLA" means a state operated living alternative program for adults that is operated by DDD.

"State supplementary payment" or "SSP" is the state paid cash assistance program for certain DDD eligible Social Security Income clients per chapter 388-827 WAC.

"Supported living" or "SL" refers to residential services provided by ADSA certified residential agencies to clients living in homes that are owned, rented, or leased by the clients or their legal representatives.

"Waiver personal care" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations per chapter 388-106 WAC to individuals who are authorized to receive services available in the Basic, Basic Plus, and Core waivers per chapter 388-845 WAC.

"Waiver respite care" means short-term intermittent relief for persons normally providing care to individuals who are authorized to receive services available in the Basic, Basic Plus, and Core waivers per chapter 388-845 WAC.

"You/Your" means the client.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1040 What is the DDD assessment?

(1) The DDD assessment is an assessment tool designed to measure the support needs of persons with developmental disabilities.

(2) The DDD assessment has three modules:

(a) The support assessment (see WAC 388-828-2000 to 388-828-6020);

(b) The service level assessment (see WAC 388-828-7000 to 388-828-7080); and

(c) The individual support plan (ISP) (see WAC 388-828-8000 to 388-828-8060).

(3) The DDD assessment is part of the aging and disability services administration's (ADSA) comprehensive assessment reporting evaluation system (CARE).

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1060 What is the purpose of the DDD assessment? The purpose of the DDD assessment is to provide a comprehensive assessment process that:

(1) Collects a common set of assessment information for reporting purposes to the legislature and the department.

(2) Promotes consistency in evaluating client support needs for purposes of planning, budgeting, and resource management.

(3) Identifies a level of service and/or number of hours that is used to support the assessed needs of clients who have been authorized by DDD to receive:

(a) Medicaid personal care services or DDD HCBS waiver personal care per chapter 388-106 WAC;

(b) Waiver respite care services per chapter 388-845 WAC;

(c) Services in the voluntary placement program (VPP) per chapter 388-826 WAC.

(4) Records your service requests.

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[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1080 Who must administer the DDD assessment? Only DDD employees can administer the DDD assessment.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1100 Who receives the DDD assessment? DDD must administer a DDD assessment when you meet any of the following conditions:

(1) You are currently approved by DDD to receive a DDD paid service evidenced by meeting one of the conditions in WAC 388-828-1440;

(2) You request enrollment in one of the DDD HCBS waivers per chapter 388-845 WAC;

(3) You are age three or older and request a DDD assessment;

(4) You have been determined eligible for categorically needy medical coverage per WAC 388-475-0100 and requested one of the following Medicaid state plan services:

(a) You have requested an assessment for Medicaid personal care services per chapter 388-106 WAC; or

(b) You have been approved to receive private duty nursing services for clients seventeen years of age and younger per WAC 388-551-3000.

(5) You are receiving SSP in lieu of a DDD paid service per chapter 388-827 WAC;

(6) You request admission to a RHC per Title 42 CFR 440, Title 42 CFR 483, and Title 71A RCW;

(7) You reside in a RHC or community ICF/MR and you are involved in discharge planning for community placement;

(8) You do not meet any of the conditions listed in WAC 388-828-1120.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1100, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1120 Who does not receive the DDD assessment? DDD will not administer the DDD assessment when you meet any of the following conditions:

(1) You have not identified a person willing to receive notice or correspondence on your behalf regarding specific DDD decisions as required per RCW 71A.10.060 and DDD does not believe you are capable of understanding department decisions that may affect your care (see WAC 388-828-1140); or

(2) A respondent cannot be identified to participate in your DDD assessment (see WAC 388-828-1540(c));

(3) You reside in a RHC and are not currently involved in discharge planning for community placement;

(4) You reside in a community ICF/MR and are not authorized by DDD to receive employment/community services paid through the counties; or

(5) You are under the age of three and do not meet any of the conditions in WAC 388-828-1100.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1120, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1140 What will DDD do if there is no one willing to receive notice on your behalf regarding spe-

cific DDD decisions? If there is no one available to receive notice or correspondence on your behalf regarding specific DDD decisions, DDD will do all of the following:

(1) Consult with the assistant attorney general to determine if:

- (a) You are able to represent yourself; or
- (b) You require a legal representative/guardian.

(2) Continue current services until the issue is resolved per section (1) above.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1140, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1160 Does everyone receive all three modules of the DDD assessment? (1) The support assessment module is administered to all clients who receive a DDD assessment.

(2) Only clients receiving a DDD paid service, SSP in lieu of a DDD paid service, or who are approved for a DDD paid service will receive the service level assessment and individual support plan modules since these modules are required:

- (a) Prior to the authorization/reauthorization of a DDD paid service or SSP; and
- (b) To determine a service level and/or number of hours for a service; and
- (c) To authorize the DDD approved paid service(s) per WAC 388-828-8000.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1160, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1180 How will your assessed unmet need(s) be met if there is no approved funding to provide a DDD paid service? If you complete the DDD assessment and are assessed to have an unmet need and there is no approved funding to support that need, DDD will offer you referral information for ICF/MR services per Title 71A RCW, chapter 388-825 WAC, and chapter 388-837 WAC. In addition, DDD may:

- (1) Provide information and referral for non-DDD community based supports; and
- (2) Add your name to the waiver data base, if you have requested enrollment in a DDD HCBS waiver per chapter 388-845 WAC; and
- (3) Authorize short-term emergency services as an exception to rule (ETR) per WAC 388-440-0001.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1180, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1200 Will DDD ask your family to disclose financial and dependent information? DDD will only ask for information regarding your family's annual gross income and the number of household dependents when:

- (1) You are age seventeen or younger; and
- (2) Your family has not made a request for your admission to a residential habilitation center (RHC).

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1200, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1220 Will DDD require your family to provide supporting documentation of their annual gross

income and number of household dependents? DDD accepts your family's verbal report and does not require your family to provide supporting documentation of their annual gross income and number of household dependents.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1220, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1240 What does DDD do when family income and household dependent information are not provided? If you meet the criteria in WAC 388-828-1200 and your family does not report family income and dependent information, the only consequence will be a denial for any new state only DDD paid services.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1240, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1260 What action will DDD take if your family does not report income and dependent information? If during your DDD assessment your family does not report family income and dependent information, DDD will:

- (1) Ask if you would like referral information for ICF/MR services; and
- (2) Continue to administer your DDD assessment; and
- (3) Continue to authorize the DDD paid services or SSP you are receiving at the time of your DDD assessment if you continue to meet the eligibility requirements for those services.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1260, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1280 How will your access to, or receipt of, DDD HCBS waiver services be affected if your family does not report family income and dependent information? Your waiver eligibility or right to request waiver enrollment is not affected if your family does not report family income and dependent information.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1280, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1300 How will your access to, or receipt of, Medicaid personal care, private duty nursing services, or SSP be affected if your family does not report family income and dependent information? Your access to, or receipt of, Medicaid personal care services per chapter 388-106 WAC, Private duty nursing services for children seventeen years of age and younger per WAC 388-551-3000, or SSP per chapter 388-827 WAC is not affected if your family does not report income and dependent information.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1300, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1320 What happens if you are approved to receive a DDD paid service and you refuse to have a DDD assessment administered? If you are approved to receive a DDD paid service and refuse to have a DDD assessment administered, DDD is unable to authorize new or current DDD paid services and will do all of the following:

- (1) Explain what happens if you refuse to allow DDD to administer the DDD assessment to you, your respondents,

and the person you have identified to receive notice on your behalf per RCW 71A.10.060.

(2) Consult with the assistant attorney general when you have not identified a person to receive notice on your behalf per RCW 71A.10.060 to determine if:

- (a) You are able to represent yourself; or
- (b) You require a legal representative/guardian.

(3) Terminate existing DDD paid services when they reach their authorized end date.

(4) Provide you notice and appeal rights for denied and/or terminated service(s) per WAC 388-825-100 and 388-825-120.

(5) Provide you with information on how to contact DDD in case you later decide you want a DDD assessment administered.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1320, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1340 After administering the DDD assessment, how long does DDD have to complete your DDD assessment? (1) DDD will complete your DDD assessment as soon as possible after it is administered.

(2) DDD will complete your DDD assessment no later than thirty days from the date it was created in CARE.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1340, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1360 Are there any exceptions to completing your DDD assessment within thirty days? DDD will not complete your DDD assessment when:

- (1) You are approved to receive a DDD paid service; and
- (2) You or your legal guardian has not identified an ADSA contracted provider.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1360, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1380 What will DDD do if you are unable to identify an ADSA contracted provider? If you are unable to identify an ADSA contracted provider, DDD will provide you or your legal guardian with contact information for ADSA contracted agency providers.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1380, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1400 What is your responsibility when selecting and/or hiring an ADSA contracted individual provider? You or your legal representative/guardian has the primary responsibility for identifying, hiring, supervising, and/or terminating an ADSA contracted individual provider.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1400, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1420 What is your responsibility when selecting an ADSA contracted agency provider? You or your legal representative/guardian has the responsibility of choosing an agency provider. DDD or the county will provide you information on contracted and qualified agency providers.

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[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1420, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1440 What is the definition of DDD "paid service" in chapter 388-828 WAC? For the purpose of this chapter, a DDD paid service is defined as an authorization of a program and/or service as evidenced by one or more of the following:

(1) An open social service payment system (SSPS) authorization within the past ninety days used for payment of a service or SSP; or

(2) A current county service authorization for one of the following services:

(a) Person to person; or

(b) Individual employment; or

(c) Group supported employment; or

(d) Prevocational/specialized industries; or

(e) Community access; or

(f) Individual and family assistance.

(3) A current waiver POC or waiver ISP; or

(4) Residence in a state operated living alternative (SOLA) program; or

(5) Authorization of family support services within the last twelve months per chapter 388-825 WAC; or

(6) Documentation of DDD approval of your absence from DDD paid services for more than ninety days with available funding for your planned return to services; or

(7) Evidence of approval for funding of a DDD service or enrollment in a DDD HCBS waiver; or

(8) Payment of services using Form A-19 state of Washington invoice voucher for receipt of:

(a) Dangerous mentally ill offender funds;

(b) Crisis stabilization services;

(c) Specialized psychiatric services; or

(d) Diversion bed services.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1440, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1460 When will you receive an initial DDD assessment? DDD intends to assess all clients per WAC 388-828-1100 by June 30, 2008. DDD must administer an initial DDD assessment when:

(1) You are receiving a DDD paid service and your annual reassessment is due for continuation of the DDD paid service; or

(2) You are receiving a DDD paid service and a reassessment is needed due to a significant change that may affect your support needs; or

(3) You are receiving SSP in lieu of a DDD paid service and your eligibility for SSP needs to be redetermined per WAC 388-827-0120;

(4) You are approved for funding of a DDD paid service and an assessment must be performed prior to the authorization of services; or

(5) You make a request to have a DDD assessment administered and meet the criteria in WAC 388-828-1100; or

(6) You are contacted by DDD and offered an opportunity to have a DDD assessment.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1460, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1480 Are there any exceptions allowing authorization of a DDD paid service prior to administering a DDD assessment? During the year prior to July 2008, due to staff resources, DDD may authorize or reauthorize the following services before a DDD assessment is administered:

- (1) Funding from the legislature that provides resources for services to be available by a certain date;
- (2) The annual reallocation of dollars for traditional family support in June 2007; or
- (3) Emergency services as determined by DDD as critical to the client's health and safety.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1480, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1500 When does DDD conduct a reassessment? A reassessment must occur:

- (1) On an annual basis if you are receiving a paid service or SSP; or
- (2) When a significant change is reported that may affect your need for support. (E.g., changes in your medical condition, caregiver status, behavior, living situation, employment status.)

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1500, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1520 Where is the DDD assessment and reassessment administered? The DDD assessment and reassessment are administered in your place of residence.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1520, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1540 Who participates in your DDD assessment? (1) All relevant persons who are involved in your life may participate in your DDD assessment, including your parent(s), legal representative/guardian, advocate(s), and service provider(s).

(2) DDD requires that at a minimum: You, one of your respondents, and your DDD case resource manager/social worker participate in your DDD assessment interview. In addition:

(a) If you are under the age of eighteen, your parent(s) or legal guardian(s) must participate in your DDD assessment interview.

(b) If you are age eighteen or older, your court appointed legal representative/guardian must be consulted if he/she does not attend your DDD assessment interview.

(c) If you are age eighteen and older and have no legal representative/guardian, DDD will assist you to identify a respondent.

(d) DDD may require additional respondents to participate in your DDD assessment interview, if needed, to obtain complete and accurate information.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1540, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1560 Do all questions in the DDD assessment have to be answered? All questions in the DDD assessment that are on a mandatory panel must be answered.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1560, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1580 Why does DDD require all questions on mandatory panels to be answered in the DDD assessment? DDD requires that all questions on mandatory panels be answered because:

(1) The legislature has directed DDD to assess all eligible clients with a common, standardized assessment process that measures the support needs of individuals with developmental disabilities.

(2) The DDD assessment algorithms in the support assessment module are designed to:

(a) Determine acuity scores and acuity levels for a variety client needs; and

(b) Provide a valid measure of each client's support needs relative to the support needs of other clients who have received the DDD assessment.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1580, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1600 What happens if you refuse to answer a question on a mandatory panel in the DDD assessment? If you refuse to answer a question on a mandatory panel in the DDD assessment, DDD is unable to complete your DDD assessment and will do all of the following:

(1) Explain what happens if you refuse to answer a question on a mandatory panel to you, your respondents, and the person you have identified to receive notice on your behalf per RCW 71A.10.060.

(2) Consult with the assistant attorney general when you have not identified a person to receive notice on your behalf per RCW 71A.10.060 to determine if:

(a) You are able to represent yourself; or

(b) You require a legal representative/guardian.

(3) Terminate existing DDD paid services when they reach their authorized end date;

(4) Provide you notice and appeal rights for denied and/or terminated service(s) per WAC 388-825-100 and 388-825-120; and

(5) Provide you with information on how to contact DDD in case you later decide you want a DDD assessment administered.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1600, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1620 How does DDD determine which panels are mandatory in your DDD assessment? DDD determines which panels are mandatory in your DDD assessment by assigning you to a client group using the following table:

| If you are approved by DDD to receive: | Your client group is: |
|---|-----------------------------------|
| (1) DDD DCBS waiver services per chapter 388-845 WAC; or (2) State-only residential services per chapter 388-825 WAC; or (3) ICF/MR services per 42 CFR 440 and 42 CFR 483. | Waiver and State-Only Residential |

| | |
|--|------------------------------|
| If you are approved by DDD to receive: | Your client group is: |
| (4) Medicaid personal care (MPC) per chapter 388-106 WAC; or (5) DDD HCBS Basic, Basic Plus, or Core waiver services per chapter 388-845 WAC and personal care services per chapter 388-106 WAC; or (6) Medically intensive health care program services per chapter 388-551 WAC; or (7) Adult day health services per chapter 388-106 WAC; or (8) Private duty nursing services per chapter 388-106 WAC; or (9) Community options program entry system (COPES) services per chapter 388-106 WAC; or (10) Medically needy residential waiver services per chapter 388-106 WAC; or (11) Medicaid nursing facility care services per chapter 388-106 WAC. | Other Medicaid Paid Services |
| (12) County employment services per chapter 388-850 WAC. (13) Other DDD paid services per chapter 388-825 WAC, such as: (a) Family support services; or (b) Professional services. (14) Nonwaiver voluntary placement program services per chapter 388-826 WAC; (15) SSP only per chapter 388-827 WAC; | State-Only Paid Services |
| (16) You are not approved to receive any DDD paid services. | No Paid Services |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1620, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1640 What are the mandatory panels in your DDD assessment? After DDD has determined your client group, DDD determines the mandatory panels in your DDD assessment using the following tables. An "X" indicates that the panel is mandatory; an "O" indicates the panel is optional. If it is blank, the panel is not used.

(1) DDD "Assessment main" and client details information

| DDD Assessment Panel Name | Client Group | | | |
|---------------------------|------------------|-----------------------------------|------------------------------|--------------------------|
| | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State Only Paid Services |
| Assessment Main | X | X | X | X |
| Demographics | X | X | X | X |
| Overview | X | X | X | X |
| Addresses | X | X | X | X |
| Collateral Contacts | X | X | X | X |
| Financials | X | X | X | X |

(2) Supports intensity scale assessment

| DDD Assessment Panel Name | Client Group | | | |
|---------------------------|------------------|-----------------------------------|------------------------------|--------------------------|
| | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State-Only Paid Services |
| Home Living | X | X | X | X |
| Community Living | X | X | X | X |
| Lifelong Learning | X | X | X | X |
| Employment | X | X | X | X |
| Health & Safety | X | X | X | X |
| Social Activities | X | X | X | X |
| Protection & Advocacy | X | X | X | X |

(3) Support assessment for children

| DDD Assessment Panel Name | Client Group | | | |
|---|------------------|-----------------------------------|------------------------------|--------------------------|
| | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State-Only Paid Services |
| Activities of Daily Living | X | X | X | X |
| IADLs (Instrumental Activities of Daily Living) | X | X | X | X |
| Family Supports | X | X | X | X |
| Peer Relationships | X | X | X | X |
| Safety & Interactions | X | X | X | X |

(4) Common support assessment panels

| DDD Assessment Panel Name | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State-Only Paid Services |
|---------------------------|------------------|-----------------------------------|------------------------------|--------------------------|
| Medical Supports | X | X | X | X |
| Behavioral Supports | X | X | X | X |
| Protective Supervision | X | X | X | X |
| DDD Caregiver Status* | X | X | X | X |
| Programs and Services | X | X | X | X |

*Information on the DDD Caregiver Status panel is not mandatory for clients receiving paid services in an AFH, SL, GH, SOLA, or RHC.

(5) Service level assessment panels

| DDD Assessment Panel Name | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State-Only Paid Services |
|--------------------------------|------------------|-----------------------------------|------------------------------|--------------------------|
| Environment | | X | X | O |
| Medical Main | | O | X | O |
| Medications | | X | X | X |
| Diagnosis | | X | X | X |
| Seizures | | X | X | X |
| Medication Management | | X | X | X |
| Treatments/programs | | X | X | X |
| ADH (Adult Day Health) | | O | O | O |
| Pain | | X | X | X |
| Indicators-Main | | O | X | O |
| Allergies | | X | X | X |
| Indicators/Hospital | | X | X | X |
| Foot | | X | X | O |
| Skin | | X | X | O |
| Skin Observation | | O | O | O |
| Vitals/Preventative | | X | X | O |
| Comments | | O | O | O |
| Communication-Main | | O | X | O |
| Speech/Hearing | | O | X | O |
| Psych/Social | | O | X | O |
| MMSE (Mini-Mental Status Exam) | | O | X | O |
| Memory | | O | X | O |
| Behavior | | O | X | O |
| Depression | | O | X | O |
| Suicide | | O | O | O |
| Sleep | | O | O | O |
| Relationships & Interests | | O | O | O |
| Decision Making | | O | X | O |
| Goals | | X | O | O |
| Legal Issues | | O | O | O |
| Alcohol | | O | O | O |
| Substance Abuse | | O | O | O |
| Tobacco | | O | X | O |
| Mobility Main | | O | X | O |
| Locomotion In Room | | O | X | O |
| Locomotion Outside Room | | O | X | O |
| Walk in Room | | O | X | O |
| Bed Mobility | | O | X | O |
| Transfers | | O | X | O |
| Falls | | O | O | O |
| Toileting-Main | | O | X | O |
| Bladder/Bowel | | O | X | O |
| Toilet Use | | O | X | O |
| Eating-Main | | O | X | O |
| Nutritional/Oral | | O | X | O |

| DDD Assessment Panel Name | No Paid Services | Waiver and State Only Residential | Other Medicaid Paid Services | State-Only Paid Services |
|---------------------------|------------------|-----------------------------------|------------------------------|--------------------------|
| Eating | | O | X | O |
| Meal Preparation | | O | X | O |
| Hygiene-Main | | O | X | O |
| Bathing | | O | X | O |
| Dressing | | O | X | O |
| Personal Hygiene | | O | X | O |
| Household Tasks | | O | X | O |
| Transportation | | O | X | O |
| Essential Shopping | | O | X | O |
| Wood Supply | | O | X | O |
| Housework | | O | X | O |
| Finances | | O | O | O |
| Pet Care | | O | O | O |
| Functional Status | | O | O | O |
| Employment Support* | | X* | X* | X* |
| Mental Health | | X | X | X |
| DDD Sleep* | | X* | O | O |

*Indicates that:
 (a) The "Employment Support" panel is mandatory only for clients age twenty-one and older who are on or being considered for one of the county services listed in WAC 388-828-1440(2).
 (b) The "DDD Sleep" panel is mandatory only for clients who are age eighteen or older and who are receiving:
 (i) DDD HCBS Core or Community Protection waiver services; or
 (ii) State-Only residential services.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1640, filed 4/23/07, effective 6/1/07.]

WAC 388-828-2000 What is the support assessment module? The support assessment module is the first section of the DDD assessment and is administered to all DDD clients.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-2000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-2020 What is the purpose of the support assessment module? The purpose of the support assessment module is to:

- (1) Collect a common set of assessment information that is scored for all persons who are eligible to receive a DDD assessment per WAC 388-828-1100;
- (2) Promote a consistent process to evaluate client support needs;
- (3) Determine whether a person meets the ICF/MR level of care standard for potential waiver eligibility; and
- (4) Identify the persons receiving, or approved for, DDD paid services or SSP who will need the additional two assessment modules:
 - (a) The service level assessment module; and
 - (b) The individual support plan module.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-2020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-2040 What components are contained in the support assessment module? The support assessment module contains the following components:

- (1) The support assessment for children;
- (2) The supports intensity scale (SIS) assessment;
- (3) DDD protective supervision acuity scale;
- (4) DDD caregiver status acuity scale;
- (5) DDD activities of daily living (ADL) acuity scale;
- (6) DDD behavioral acuity scale;
- (7) DDD medical acuity scale;
- (8) DDD interpersonal support acuity scale;
- (9) DDD mobility acuity scale;
- (10) DDD respite assessment; and
- (11) Programs and services component.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-2040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-2060 How does your assessment age affect the support assessment module? Age guidelines are incorporated into the support assessment module to exclude age appropriate supports unrelated to a disability. The following table illustrates which components DDD includes in your support assessment module based on your assessment age:

| Components contained in the Support Assessment module | Age (0-15) | Age (16+) |
|---|------------|-----------|
| The Support Assessment for Children | Yes | No |
| SIS Support Needs and Supplemental Protection and Advocacy Scales | No | Yes |
| SIS Exceptional Medical and Behavior Support Needs Scales | Yes | Yes |
| DDD Protective Supervision Acuity Scale | Yes | Yes |
| DDD Caregiver Status Acuity Scale | Yes | Yes |
| DDD Activities of Daily Living Acuity Scale | Yes | Yes |
| DDD Behavioral Acuity Scale | Yes | Yes |

| | | |
|---|------------|-----------|
| Components contained in the Support Assessment module | Age (0-15) | Age (16+) |
| DDD Medical Acuity Scale | Yes | Yes |
| DDD Interpersonal Support Acuity Scale | Yes | Yes |
| DDD Mobility Scale | Yes | Yes |
| Current Programs and Services component | Yes | Yes |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-2060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-2080 How does DDD determine your assessment age? If you are within thirty calendar days of your next birthday, DDD determines your assessment age to be that of your next birthday.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-2080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-3000 What is the purpose of the support assessment for children? The support assessment for children measures the support needs of children from birth to age fifteen.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-3000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-3020 What is the purpose of the support assessment for children? The purpose of the support assessment for children ages fifteen or younger is to determine:

(1) Your ICF/MR level of care score for DDD HCBS waiver eligibility;

(2) The health and welfare needs that must be addressed in your individual support plan if you are enrolled in a DDD HCBS waiver; and

(3) Your support need levels for:

- (a) The DDD activities of daily living acuity scale;
- (b) The DDD interpersonal support acuity scale; and
- (c) The DDD mobility acuity scale.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-3020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-3040 What questions are asked in the support assessment for children and how are they scored? DDD scores the answers to each of the following questions in the support assessment for children based on the respondent information:

(1) Dress and groom self: What support does the child need to dress and groom self as expected of others of same age?

| Answers | Definitions | LOC Score | Acuity Score |
|-----------------------------------|--|-----------|--------------|
| Physical Assistance | Needs major support in the form of total physical assistance, intensive training and/or therapy for dressing and grooming. | 1 | 4 |
| Training | Needs moderate support in the form of some physical assistance and/or training and/or therapies to dress and groom self. | 0 | 3 |
| Reminders/Prompts | Needs reminders or prompts to dress and groom self appropriately. | 0 | 2 |
| No support needed or at age level | At age level (may have physical supports) in dressing and grooming. | 0 | 0 |

(2) Toilet self: What support does the child need to toilet self as expected of others in his/her age group?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Needs major support in the form of total physical support. Intensive training intervention and/or daily therapy to toilet self. | 1 | 4 |
| Partial physical assistance, training | Needs moderate support in the form of some physical assistance, standard training and/or regular therapy. | 0 | 3 |
| Reminders/prompts | Needs reminders or prompts. | 0 | 2 |
| No support needed or at age level | Toilets self or has physical support in place to toilet self. | 0 | 0 |

(3) Eat at age level: What support does the child need to eat at age level?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Total physical support | Needs major support in the form of total physical assistance, intensive training and/or daily therapy. | 1 | 4 |
| Partial physical assistance, training | Needs moderate support in the form of some physical assistance, standard training, and/or regular therapy. | 1 | 3 |
| Reminders/prompts | Needs help with manners and appearance when eating, in the form of reminders and prompts. | 0 | 2 |
| No support needed or at age level | At age level (may have physical supports) in eating. | 0 | 0 |

(4) Move around: What support does the child need to move around in the same ways as other children of same age?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Needs major intervention in the form of total physical support to move around, intensive training and/or daily therapy. | 1 | 4 |
| Partial physical assistance, training | Needs moderate support such as someone's help to move around or may use or learn to use adaptive device or may require standard training. | 1 | 3 |
| Reminders/prompts | Needs mild intervention in the form of training and physical prompting for scooting/crawling/walking behaviors. | 0 | 2 |
| No support needed or at age level | No supports needed - child is scooting/crawling/walking at age level | 0 | 0 |

(5) Communicate: What support does the child need to communicate as others of same age?

| Answers | Definitions | LOC Score | Acuity Score |
|------------------------------------|---|-----------|--------------|
| Total physical support | Currently someone else must always determine and communicate child's needs. | 1 | 4 |
| Training/therapy | With intensive training or therapy support, child may learn sufficient verbal and/or signing skills to make self easily understandable to others. May include partial physical support. | 1 | 3 |
| Adaptive device/interpreter | With physical support (adaptive device, interpreter), child is always able to communicate. | 0 | 2 |
| No support needed or at age level | No supports needed and/or at age level. | 0 | 0 |

(6) Learn about and use money: What support does the child need to learn about and use money?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Child is not old enough to know about money. | 0 | 4 |
| Partial physical assistance, training | Family must devise special opportunities for child to earn/or spend money. | 0 | 3 |
| Create opportunities, reminders/prompts | Needs to learn about earning and/or spending money in typical age-level ways. | 0 | 2 |
| No support needed or at age level | Needs no support. Independently uses opportunities typical to his/her age group to earn and/or spend money. | 0 | 0 |

(7) Make choices and take responsibility: What support does the child need to make choices and take responsibility?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Total physical support | Needs major support in the form of special and/or technical help to and from family/teachers to create opportunities for making choices and taking responsibility. | 1 | 4 |
| Partial physical assistance, training | Needs moderate support in the form of family/teachers creating and explaining a variety of opportunities for making choices and taking responsibility. | 1 | 3 |
| Create opportunities, reminders/prompts | Needs some support in the form of explanation of available options for making choices and taking responsibility. | 1 | 2 |
| No support needed or at age level | Needs no support. Readily uses a variety of opportunities to indicate choices (activity, food, etc.) and take responsibility for tasks, self, etc. | 0 | 0 |

(8) Explore environment: What support does the child need to explore environment?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Total physical support | Needs major support in the form of specialized technical help to and from family/teachers to create ways which support/encourage child to explore and reach out. | 1 | 4 |
| Partial physical assistance, training | Needs moderate support in the form of some training/physical help to and from family and teachers to create ways and opportunities for child to explore environment and reach out. | 1 | 3 |
| Reminders/prompts | Needs some support in the form of verbal encouragement or presence of someone child trusts to explore environment and reach out. | 0 | 2 |

| Answers | Definitions | LOC Score | Acuity Score |
|-----------------------------------|--|-----------|--------------|
| No support needed or at age level | Needs no support and/or is at age level. Readily explores environment (may have adaptive device) and reaches out in ways typical to child's age group. | 0 | 0 |

(9) Meet therapy health needs: What supports are necessary to get child's therapy health needs met?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Daily intervention by professionals | Child requires medical/health intervention or monitoring by professionals at least daily. | 1 | 4 |
| Monitoring by health professionals | Child needs regular (weekly, monthly) monitoring by health professionals. | 1 | 3 |
| Monitoring by trained others | Child needs daily support and/or monitoring by training others. | 1 | 2 |
| Community health system | Needs regular on-going therapy and/or monitoring of health needs through typical community health systems. | 0 | 1 |
| No support needed or at age level | No specialized supports or ongoing therapies necessary. | 0 | 0 |

(10) Help family continue to meet child's needs: What support services should the system provide to help family continue to meet child's needs?

| Answers | Definitions | LOC Score | Acuity Score |
|---|---|-----------|--------------|
| Urgent extensive support | Substantial significant supports to child and parents needed. Child in, or at risk of, out-of-home placement at this time. | 1 | 4 |
| Substantial support/referrals needed | Substantial support needed/requested; (e.g., requests for more than two days per month respite, referral to homemakers, homebuilders; request for long term behavior management training, need extensive and/or expensive environmental modification or equipment; request frequent contact with case manager.) | 1 | 3 |
| Moderate support | Moderate external support needed/requested; (e.g., requests for regular respite, intensive but short-term behavior management, referral for parent training help, referral to day care services; and/or request for regular contact with case manager.) | 0 | 2 |
| Minimal support | Minimal external support needed/requested; (e.g., requests for occasional respite, referrals to parent support group, and/or case manager helps obtain adaptive equipment.) | 0 | 1 |
| No support needed or at age level | No external supports are necessary. Family has obtained any necessary adaptive equipment. | 0 | 0 |

(11) Have relationships with family members: What support does the child need to make the kind of relationships with family members expected of nondisabled children of the same age?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Opportunities for contributing to family life totally dependent on others to maintain, interpret child's role to other family members. | 0 | 4 |
| Partial physical assistance, training | Requires major support in the form of daily/weekly creation of opportunities to be seen as a contributing member and assume typical family responsibilities. | 0 | 3 |
| Reminders/prompts | Requires moderate support in the form of adaptive device, training and/or reminders to be seen as contributing member and assume typical family responsibilities. | 0 | 2 |
| No support needed or at age level | Needs no support to form positive family relationship. | 0 | 0 |

(12) Explore and use typical community resources: What support does the child need to explore and use typical community resources such as stores, parks, and playgrounds?

| Answers | Definitions | LOC Score | Acuity Score |
|-------------------------------|--|-----------|--------------|
| Total physical support | Family needs major support (perhaps respite) to continue to provide child total physical support to use typical resources. | 0 | 4 |

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Partial physical assistance, training | Moderate support is needed - family must create ways for child to use these resources in ways typical to child's age group. | 0 | 3 |
| Reminders/prompts | Minimal support needed - family may wish suggestions or some support on ways to enable child's regular use of typical resources. | 0 | 2 |
| No support needed or at age level | Needs no support and/or at age level. Uses these resources regularly. | 0 | 0 |

(13) Play with others: What supports are needed for the child to develop age-level skills in playing with others?

| Answers | Definitions | LOC Score | Acuity Score |
|---|---|-----------|--------------|
| Total physical support | Major support needed by others to help child play. Parents may request special adaptive equipment and training to foster child's playing skills. | 0 | 4 |
| Partial physical assistance training | Moderate support needed in the form of a verbal and/or some physical intervention to help child play. Parents may be requesting suggestions instruction in ways to help child develop playing skills. | 0 | 3 |
| Reminders/prompts | Minimal support needed. | 0 | 2 |
| No support needed or at age level | No supports needed and/or at age level. Child's playing skills developing at age level. | 0 | 0 |

(14) Have opportunities to play with typically developing children: What supports does the child need to have opportunities to play with typically developing children?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Substantial system support (e.g., system must set up "programs" that allow for interaction with typically developing children and the "programs"). | 0 | 4 |
| Partial physical assistance, training | Moderate supports (e.g., parents have to create opportunities for contacts). Parents may ask for instruction in how to facilitate such contacts. System may need to provide structural supports (e.g., transportation, barrier-free public play environments, etc). | 0 | 3 |
| Reminders/prompts | Minimal support (e.g., some monitoring). Parents may request help on how to broaden child's range of contacts or to increase the age appropriateness of contacts. | 0 | 2 |
| No support needed or at age level | No support needed. | 0 | 0 |

(15) Identify and respond safely to emergencies: What support does the child need to identify and respond safely to emergencies?

| Answers | Definitions | LOC Score | Acuity Score |
|---|--|-----------|--------------|
| Total physical support | Needs total physical support to respond to emergencies. | 1 | 4 |
| Always needs help to identify and respond | Needs help all of the time to identify emergencies and to respond. | 1 | 3 |
| Sometimes needs help to identify and respond | Needs help some of the time to identify emergencies and to respond. | 1 | 2 |
| Can identify, needs help to respond | Independently identifies emergencies; needs help from others to respond. | 1 | 1 |
| No help needed or at age level | Needs no help from others in emergencies. | 0 | 0 |

(16) Practice age-level safety measures: What support does the child need to practice age-level safety measures?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Total physical support | Needs total physical support for safety measures in daily activities and routines. | 1 | 4 |
| Partial physical assistance, training | Does not recognize own safety needs and requires help in most safety areas. | 1 | 3 |
| Reminders/prompts | Knows importance of safety measures. Needs training and/or physical support in many areas. | 1 | 2 |

| Answers | Definitions | LOC Score | Acuity Score |
|-----------------------------------|---|-----------|--------------|
| No support needed or at age level | Needs no support in providing for own safety. | 0 | 0 |

(17) Effectively relate to other students/peers: What support does the child need to most effectively relate to fellow students and/or peers?

| Answers | Definitions | LOC Score | Acuity Score |
|--|---|-----------|--------------|
| Total physical support | Needs physical support by others in the form of interpretation of self to others to interact with peers. | 1 | 4 |
| Partial physical assistance, training | Needs physical intervention in the form of modeling to enable child to reach out to peers to give and take support. | 1 | 3 |
| Reminders/prompts | Needs much encouragement, supervision and guidance in how to give and ask for support and interact with peers. | 0 | 2 |
| No support needed or at age level | Without support, child relates to others as a valued member of work/learning unit. | 0 | 0 |

(18) Have behaviors which promote being included: What support is needed for this child to have behaviors which promote being included?

| Answers | Definitions | LOC Score | Acuity Score |
|--|--|-----------|--------------|
| Continuous behavioral interventions | Needs major tolerance and control. Could include being dangerous to self and/or others. | 1 | 4 |
| Major behavior modifications | Needs major behavior modifications to be perceived as typical. Child's behaviors are extremely disagreeable to others. | 1 | 3 |
| Modeling, reminders, prompts | Needs participation in typical settings with typically developing others to model desirable behaviors. Child's behaviors cause him/her to be easily recognized as different from others. | 0 | 2 |
| Minor support | Needs interactions with typically developing others. Child's behaviors are different from others in minor ways and the child may not immediately be perceived as different. | 0 | 1 |
| No support needed or at age level | Needs no support. Behaviors are similar to others in general community of same age and culture. | 0 | 0 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-3040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-3060 How does DDD determine your total LOC score for ICF/MR level of care if you are age birth through fifteen years old? DDD determines your total LOC score for ICF/MR level of care by adding all of your LOC scores on questions one through eighteen in the support assessment for children.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-3060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-3080 How does DDD determine if you meet the eligibility requirements for ICF/MR level of care (LOC) if you are age birth through fifteen years old? DDD determines you are eligible for ICF/MR level of care when:

- (1) You are age birth through five years old and the total of your LOC scores is five or more; or
- (2) You are age six through fifteen years old and the total of your LOC scores is seven or more.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-3080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4000 What is the supports intensity scale (SIS) assessment? The supports intensity scale assessment is a standardized tool developed by the American Association on Intellectual and Developmental Disabilities

(AAIDD), to measure the relative intensity of support needs for persons age sixteen and older.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4020 What is the purpose of the supports intensity scale (SIS) assessment? The purpose of the supports intensity scale assessment in the DDD assessment is to determine all of the following:

- (1) Your ICF/MR level of care score for DDD HCBS waiver eligibility;
- (2) The health and welfare needs that must be addressed in your individual support plan if you are enrolled in a DDD HCBS waiver;
- (3) Your DDD behavioral and medical acuity levels regardless of your age; and
- (4) Your support need acuity levels specific to the:
 - (a) DDD activities of daily living acuity scale;
 - (b) DDD interpersonal support acuity scale; and
 - (c) DDD mobility acuity scale.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4040 What scales are contained in the supports intensity scale (SIS) assessment? The supports intensity scale assessment contains the following:

- (1) The support needs scale;
- (2) The supplemental protection and advocacy scale;
- (3) Exceptional medical support needs scale; and
- (4) Exceptional behavioral support needs scale.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4060 What subscales are contained in the support needs scale? The support needs scale contains the following subscales:

- (1) Home living activities;
- (2) Community living activities;
- (3) Lifelong learning activities;
- (4) Employment activities;
- (5) Health and safety activities; and
- (6) Social activities.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4080 How does the SIS measure your support need(s) in the support needs and supplemental protection and advocacy scales? The SIS measures your support needs in the support needs and supplemental protection and advocacy scales using the following three dimensions of support intensity:

- (1) Type of support;
- (2) Frequency of support; and
- (3) Daily support time.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4100 How is type of support scored in the SIS assessment? DDD scores the type of support you need to perform the assessed activity using the following rating scale:

| | |
|--|-------|
| Type of Support: What kind of support is needed for the assessed activity? | |
| Answer | Score |
| None | 0 |
| Monitoring | 1 |
| Verbal/gestural prompting | 2 |
| Partial physical assistance | 3 |
| Full physical assistance | 4 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4100, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4120 How is frequency of support scored in the SIS assessment? DDD scores how frequently support is needed for you to perform the assessed activity using the following rating scale:

| # | Home Living Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|----|--|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| A1 | Using the toilet | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| A2 | Taking care of clothes (includes laundering) | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| A3 | Preparing food | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| A4 | Eating food | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| A5 | Housekeeping and cleaning | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | * | * | |
| A6 | Dressing | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |

| | |
|--|-------|
| Frequency: How frequently is support needed for the assessed activity? | |
| Answer | Score |
| None or less than monthly | 0 |
| At least once a month, but not once a week | 1 |
| At least once a week, but not once a day | 2 |
| At least once a day, but not once an hour | 3 |
| Hourly or more frequently | 4 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4120, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4140 How is daily support time scored in the SIS assessment? DDD scores the amount of daily support time you need to perform the assessed activity using the following rating scale:

| | |
|--|-------|
| Daily Support Time: On a typical day when support in this area is needed, how much time should be devoted? | |
| Answer | Score |
| None | 0 |
| Less than 30 minutes | 1 |
| 30 minutes to less than 2 hours | 2 |
| 2 hours to less than 4 hours | 3 |
| 4 hours or more | 4 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4140, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4160 How does DDD determine your raw score for each of the activities that are assessed in the support needs and supplemental protection and advocacy scales? DDD adds the three dimensions of support intensity scores for each activity to determine your raw score for the activity.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4160, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4180 Are all questions in the support needs and supplemental protection and advocacy scales scored the same way? Some questions in the support needs and supplemental protection and advocacy scales have scoring limitations and some scores are not available for selection related to the standardization process per AAIDD.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4180, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4200 What activities are assessed in the home living activities subscale of the support needs scale? The home living activities subscale measures your personal support needs for the following home living activities:

| # | Home Living Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|---|--|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| A7 | Bathing and taking care of personal hygiene and grooming needs | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| A8 | Operating home appliances | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| A9 | Using currently prescribed equipment or treatment | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for home living activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. Note: Question A9 is a question added by DDD. It is for information purposes only and is not used to calculate scores or levels for service determination. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4200, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4220 What activities are assessed in the community living activities subscale of the support needs scale? The community living activities subscale measures your personal support needs for the following community living activities:

| # | Community Living Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|--|---|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| B1 | Getting from place to place throughout the community (transportation) | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| B2 | Participating in recreation/leisure activities in community settings | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| B3 | Using public services in the community | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| B4 | Going to visit friends and family | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| B5 | Participating in preferred community activities (church, volunteer, etc.) | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| B6 | Shopping and purchasing goods and services | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| B7 | Interacting with community members | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| B8 | Accessing public buildings and settings | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for community living activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4220, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4240 What activities are assessed in the lifelong learning activities subscale of the support needs scale? The lifelong learning activities subscale measures your personal support needs for the following lifelong learning activities:

| # | Lifelong Learning Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|----|--|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| C1 | Interacting with others in learning activities | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| C2 | Participating in training/educational decisions | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | * | |
| C3 | Learning and using problem-solving strategies | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| C4 | Using technology for learning | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| C5 | Accessing training/educational settings | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| C6 | Learning functional academics (reading signs, counting change, etc.) | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| C7 | Learning health and physical education skills | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| C8 | Learning self-determination skills | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |

| # | Lifelong Learning Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|---|-------------------------------------|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| C9 | Learning self-management strategies | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for lifelong learning activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4240, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4260 What activities are assessed in the employment activities subscale of the support needs scale?

The employment activities subscale measures your personal support needs for the following employment activities:

| # | Employment Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|--|---|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D1 | Accessing/receiving/job/tasks accommodations | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D2 | Learning and using specific job skills | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D3 | Interacting with co-workers | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D4 | Interacting with supervisors and/or coaches | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D5 | Completing work-related tasks with acceptable speed | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D6 | Completing work-related tasks with acceptable quality | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| D7 | Changing job assignments | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | * | * | 0 | 1 | 2 | 3 | 4 | |
| D8 | Seeking information and assistance from an employer | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for employment activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4260, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4280 What activities are assessed in the health and safety activities subscale of the support needs scale?

The health and safety activities subscale measures your personal support needs for the following health and safety activities:

| # | Health and Safety Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|---|---|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E1 | Taking medications | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E2 | Avoiding health and safety hazards | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E3 | Obtaining health care services | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | * | * | |
| E4 | Ambulating and moving about | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E5 | Learning how to access emergency services | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E6 | Maintaining a nutritious diet | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E7 | Maintaining physical health and fitness | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| E8 | Maintaining emotional well-being | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for health and safety activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4280, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4300 What activities are assessed in the social activities subscale of the support needs scale?

The social activities subscale measures your personal support needs for the following social activities:

| # | Social Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|----|---|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| F1 | Socializing within the household | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| F2 | Participating in recreation and/or leisure activities with others | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| F3 | Socializing outside the household | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| F4 | Making and keeping friends | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |

| # | Social Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|--|--|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| F5 | Communicating with others about personal needs | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| F6 | Using appropriate social skills | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| F7 | Engaging in loving and intimate relationships | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| F8 | Engaging in volunteer work | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for social activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option per AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4300, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4320 What activities are assessed in the supplemental protection and advocacy activities subscale?

The supplemental protection and advocacy activities subscale measures your personal support needs for the following protection and advocacy activities:

| # | Protection and Advocacy Activities | Type of Support | | | | | Frequency of Support | | | | | Daily Support Time | | | | | Raw Score |
|---|---|-----------------|---|---|---|---|----------------------|---|---|---|---|--------------------|---|---|---|---|-----------|
| | | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G1 | Advocating for self | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| G2 | Managing money and personal finances | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G3 | Protecting self from exploitation | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G4 | Exercising legal responsibilities | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G5 | Belonging to and participating in self-advocacy/support organizations | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G6 | Obtaining legal services | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G7 | Making choices and decisions | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 | |
| G8 | Advocating for others | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | * | 0 | 1 | 2 | 3 | 4 | |
| Total raw score for protection and advocacy activities: | | | | | | | | | | | | | | | | | |
| * = Score is not an option for AAIDD. | | | | | | | | | | | | | | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4320, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4340 How does DDD determine your support score for each of the items identified in the SIS exceptional medical and behavioral support needs scales?

DDD examines the amount of support you need for medical treatments and behavioral support using the following rating scale:

| Answer | Score |
|--------------------------|-------|
| No support needed | 0 |
| Some support needed | 1 |
| Extensive support needed | 2 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4340, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4360 What exceptional medical support activities are evaluated to assess your medical support needs? The SIS exceptional medical support needs scale measures your personal support needs for the following medical support need(s) activities:

| # | Medical Supports Needed | No Support Needed | Some Support Needed | Extensive Support Needed |
|-----|---|-------------------|---------------------|--------------------------|
| 1. | Inhalation or oxygen therapy | 0 | 1 | 2 |
| 2. | Postural drainage | 0 | 1 | 2 |
| 3. | Chest PT | 0 | 1 | 2 |
| 4. | Suctioning | 0 | 1 | 2 |
| 5. | Oral stimulation or jaw positioning | 0 | 1 | 2 |
| 6. | Tube feeding (e.g., nasogastric) | 0 | 1 | 2 |
| 7. | Parenteral feeding (e.g., IV) | 0 | 1 | 2 |
| 8. | Turning or positioning | 0 | 1 | 2 |
| 9. | Dressing of open wound(s) | 0 | 1 | 2 |
| 10. | Protection from infectious diseases due to immune system impairment | 0 | 1 | 2 |
| 11. | Seizure management | 0 | 1 | 2 |
| 12. | Dialysis | 0 | 1 | 2 |
| 13. | Ostomy care | 0 | 1 | 2 |

| # | Medical Supports Needed | No Support Needed | Some Support Needed | Extensive Support Needed |
|--|-----------------------------|-------------------|---------------------|--------------------------|
| 14. | Lifting and/or transferring | 0 | 1 | 2 |
| 15. | Therapy services | 0 | 1 | 2 |
| 16. | Diabetes Management* | 0 | 1 | 2 |
| 17. | Other(s) - Specify: | 0 | 1 | 2 |
| Subtotal scores of 1s and 2s: | | | | |
| Add subtotals scores for 1s and 2s for total exceptional medical support needs score: | | | | |
| * #16 is a question added by DDD. It is used as part of the DDD medical acuity scale and is not used to calculate SIS percentiles. | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4360, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4380 What exceptional behavioral support activities are evaluated to assess your behavioral support needs? The SIS exceptional behavioral support needs scale measures your personal support needs for the following behaviors:

| # | Behavioral Supports Needed | No Support Needed | Some Support Needed | Extensive Support Needed |
|---|---|-------------------|---------------------|--------------------------|
| 1. | Prevention of assaults or injuries to others | 0 | 1 | 2 |
| 2. | Prevention of property destruction (e.g., fire setting, breaking furniture) | 0 | 1 | 2 |
| 3. | Prevention of stealing | 0 | 1 | 2 |
| 4. | Prevention of self-injury | 0 | 1 | 2 |
| 5. | Prevention of PICA (ingestion of inedible substances) | 0 | 1 | 2 |
| 6. | Prevention of suicide attempts | 0 | 1 | 2 |
| 7. | Prevention of sexual aggression | 0 | 1 | 2 |
| 8. | Prevention of nonaggressive but inappropriate behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing) | 0 | 1 | 2 |
| 9. | Prevention of tantrums or emotional outbursts | 0 | 1 | 2 |
| 10. | Prevention of wandering | 0 | 1 | 2 |
| 11. | Prevention of substance abuse | 0 | 1 | 2 |
| 12. | Maintenance of mental health treatments | 0 | 1 | 2 |
| 13. | Managing attention-seeking behavior* | 0 | 1 | 2 |
| 14. | Managing uncooperative behavior* | 0 | 1 | 2 |
| 15. | Managing agitated/over reactive behavior* | 0 | 1 | 2 |
| 16. | Managing obsessive/repetitive behavior* | 0 | 1 | 2 |
| 17. | Prevention of other serious behavior problem(s) - Specify: | 0 | 1 | 2 |
| Subtotal scores of 1s and 2s: | | | | |
| Add subtotals scores for 1s and 2s for total exceptional behavioral support needs scores: | | | | |
| *#13-16 are questions added by DDD. They are used as part of the DDD behavior acuity scale and are not used to calculate SIS percentiles. | | | | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4380, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4400 How does DDD determine if you meet the eligibility requirements for ICF/MR level of care if you are age sixteen or older? If you are age sixteen or older, DDD determines you to be eligible for ICF/MR level of care from your SIS scores. Eligibility for ICF/MR level of care requires that your scores meet at least one of the following:

- (1) You have a percentile rank that is over nine percent for three or more of the six subscales in the SIS support needs scale;
- (2) You have a percentile rank that is over twenty-five percent for two or more of the six subscales in the SIS support needs scale;

(3) You have a percentile rank that is over fifty percent in at least one of the six subscales in the SIS support needs scale;

(4) You have a support score of one or two for any of the questions listed in the SIS exceptional medical support needs scale;

(5) You have a support score of one or two for at least one of the following items in the SIS exceptional behavior support needs scale:

- (a) Prevention of assaults or injuries to others;
- (b) Prevention of property destruction (e.g., fire setting, breaking furniture);
- (c) Prevention of self-injury;

- (d) Prevention of PICA (ingestion of inedible substances);
- (e) Prevention of suicide attempts;
- (f) Prevention of sexual aggression; or
- (g) Prevention of wandering.

- (6) You have a support score of two for any of the questions listed in the SIS exceptional behavior support needs scale; or
- (7) You meet or exceed any of the qualifying scores for one or more of the following SIS questions:

| Question # of SIS Support Needs Scale | Text of Question | Your score for "Type of Support" is: | And your score for "Frequency of Support" is: |
|---------------------------------------|--|--------------------------------------|---|
| A1 | Using the toilet | 2 or more | 4 |
| | | 3 or more | 2 |
| A2 | Taking care of clothes | 2 or more | 2 or more |
| | | 3 or more | 1 |
| A3 | Preparing food | 2 or more | 4 |
| | | 3 or more | 2 |
| A4 | Eating food | 2 or more | 4 |
| | | 3 or more | 2 |
| A5 | Housekeeping and cleaning | 2 or more | 2 or more |
| | | 3 or more | 1 |
| A6 | Dressing | 2 or more | 4 |
| | | 3 or more | 2 |
| A7 | Bathing and taking care of personal hygiene and grooming needs | 2 or more | 4 |
| | | 3 or more | 2 |
| C3 | Learning and using problem-solving strategies | 2 or more | 3 or more |
| | | 3 or more | 2 |
| C9 | Learning self-management strategies | 2 or more | 3 or more |
| | | 3 or more | 2 |
| B6 | Shopping and purchasing goods and services | 2 or more | 2 or more |
| | | 3 or more | 1 |
| E1 | Taking medication | 2 or more | 4 |
| | | 3 or more | 2 |
| E2 | Avoiding health and safety hazards | 2 or more | 3 or more |
| | | 3 or more | 2 |
| E4 | Ambulating and moving about | 2 or more | 4 |
| | | 3 or more | 2 |
| E6 | Maintaining a nutritious diet | 2 or more | 2 or more |
| | | 3 or more | 1 |
| E8 | Maintaining emotional well-being | 2 or more | 3 or more |
| | | 3 or more | 2 |
| F6 | Using appropriate social skills | 2 or more | 3 or more |
| | | 3 or more | 2 |
| G2 | Managing money and personal finances | 2 or more | 2 or more |
| | | 3 or more | 1 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4400, filed 4/23/07, effective 6/1/07.]

WAC 388-828-4420 How does DDD determine your percentile rank for each subscale in the SIS support needs scale? DDD uses the following table to convert your total raw score for each subscale into a percentile ranking:

| If your raw score for the following SIS subscale is: | | | | | | Then your percentile rank for the SIS subscale is: |
|--|------------------|-------------------|--------------------|-------------------|-------------------|--|
| Home Living | Community Living | Lifelong Learning | Employment Support | Health and Safety | Social Activities | |
| | | | | | | >99 |
| >88 | >94 | | | | | >99 |
| 87-88 | 93-94 | | | | | >99 |
| 85-86 | 91-92 | | | >97 | | 99 |
| 81-84 | 88-90 | >96 | >95 | 92-97 | >97 | 98 |
| 77-80 | 84-87 | 92-96 | 91-95 | 86-91 | 91-97 | 95 |
| 73-76 | 79-83 | 86-91 | 85-90 | 79-85 | 84-90 | 91 |
| 68-72 | 74-78 | 79-85 | 78-84 | 72-78 | 76-83 | 84 |
| 62-67 | 69-73 | 72-78 | 70-77 | 65-71 | 68-75 | 75 |

| If your raw score for the following SIS subscale is: | | | | | | Then your percentile rank for the SIS subscale is: |
|--|------------------|-------------------|--------------------|-------------------|-------------------|--|
| Home Living | Community Living | Lifelong Learning | Employment Support | Health and Safety | Social Activities | |
| 55-61 | 63-68 | 64-71 | 61-69 | 57-64 | 58-67 | 63 |
| 48-54 | 56-62 | 55-63 | 52-60 | 49-56 | 48-57 | 50 |
| 40-47 | 49-55 | 46-54 | 42-51 | 42-48 | 38-47 | 37 |
| 32-39 | 41-48 | 36-45 | 32-41 | 34-41 | 28-37 | 25 |
| 25-31 | 33-40 | 27-35 | 23-31 | 27-33 | 19-27 | 16 |
| 18-24 | 25-32 | 18-26 | 15-22 | 20-26 | 10-18 | 9 |
| 11-17 | 16-24 | 9-17 | 7-14 | 13-19 | 3-9 | 5 |
| 3-10 | 6-15 | <9 | <7 | 7-12 | <3 | 2 |
| <3 | <6 | | | 1-6 | | 1 |
| | | | | <1 | | <1 |
| | | | | | | <1 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-4420, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5000 What is the DDD protective supervision acuity scale? The DDD protective supervision acuity scale is an assessment of your protective supervision support need(s).

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5020 How is information in the protective supervision acuity scale used by DDD? (1) Information obtained in the protective supervision acuity scale is one of the factors used by DDD to determine the amount of waiver respite, if any, that you are authorized to receive.

(2) The protective supervision acuity scale is not used when determining your Medicaid personal care or waiver personal care; and

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5040 What questions are asked in the DDD protective supervision acuity scale? The three questions that are asked for the DDD protective supervision acuity scale are in WAC 388-828-5060.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5060 How does DDD score each question? DDD selects one answer per each question that best describes your reported need.

(1) What level of monitoring does the client typically require during awake hours?

| Answers | Definitions | Score |
|---|---|-------|
| Independent | Can be left unattended. Might occasionally show poor judgement, but does not require routine access to a support person. | 0 |
| Remote (e.g., a week or more) | Can be left unattended for extended periods of time, but requires access to a support person either via phone or someone who visits the person weekly or so. | 1 |
| Periodic (e.g., every couple of days) | Can be left unattended for a couple of days, but requires access to a support person who checks in every few days via telephone or in person. | 2 |
| Monitoring (e.g., half day, unstructured) | Can be left unattended for several hours at a time (2-4 hours) to engage in independent activities, but needs access to a support person daily for guidance or assistance. | 3 |
| Close proximity (e.g., 1-2 hours, structured) | Can be left unattended for short periods of time (1-2 hours), provided that the environment is strictly structured and that a support person can respond quickly in an emergency situation. | 4 |
| Onsite (e.g., on property) | Cannot be left unattended. Requires a support person on the property at all times, at least during awake hours. | 5 |
| Line of sight/earshot (e.g., close observation) | Cannot be left unattended. Requires a support person within the room or within earshot of the client's location at all times during awake hours. | 6 |

(2) What assistance does the client need to handle unfamiliar or unexpected situations?

| Answers | Definitions |
|------------------------------------|---|
| Can resolve independently | The client can generally handle unfamiliar or unexpected situations. The client shows generally good judgment and awareness of personal safety. |
| Can resolve with remote assistance | The client can handle unfamiliar or unexpected situations by calling or contacting someone remotely for assistance (e.g., by telephone or e-mail). The support person does not need to be physically present. |

| Answers | Definitions |
|--|---|
| Needs someone physically present to assist | When unfamiliar or unexpected situations occur, generally someone must be present or come to the client to help the client resolve the issue. |
| Needs full physical assistance | The client cannot generally participate in resolving such situations; someone else must resolve them. |

(3) Is client able to summon help?

| Answers | Definitions |
|---|---|
| Can call someone on telephone | Client can discern when help is needed and contact someone via telephone or other electronic means. This includes dialing 911, using speed dial to contact someone, e-mail, radio, or dialing a phone number. |
| Can seek help outside the house, nearby | Client can discern when help is needed and can summon a remote caregiver, neighbor, or other person outside the house or nearby to assist when necessary. |
| Can seek help inside house | Client can discern when help is needed and can summon a caregiver or roommate within the house to assist when necessary. |
| Cannot summon help | Client is unable to summon help or discern a dangerous situation that would require help. |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5080 How does DDD determine your adjusted protective supervision acuity score? DDD determines your adjusted protective supervision acuity score by applying the following age-based score adjustments to your level of monitoring score for question number one in WAC 388-828-5060:

| | |
|---|--|
| If you are: | Then your age-based score adjustment is: |
| 18 years or older | Score is equal to your level of monitoring score |
| 16-17 years of age | Subtract 1 from your level of monitoring score |
| 12-15 years of age | Subtract 2 from your level of monitoring score |
| 8-11 years of age | Subtract 3 from your level of monitoring score |
| 5-7 years of age | Subtract 4 from your level of monitoring score |
| 0-4 years of age | Subtract 5 from your level of monitoring score |
| If your adjusted level of monitoring score is a negative number, your adjusted protective supervision acuity score is zero. | |

Example: If you are fifteen years old and "close proximity, (e.g., 1-2 hours, structured)" is identified as your level of monitoring score, your adjusted protective supervision acuity score is: Your close proximity score of four minus age-based score adjustment of two. For age twelve through fifteen, this equals an adjusted protective supervision score of two.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5100 How does DDD determine your protective supervision support level? DDD uses the following table in determining your protective supervision support level:

| | |
|---|--|
| If your Adjusted Protective Supervision Score is: | Then your Protective Supervision Support Level is: |
| 5-6 | High |
| 3-4 | Medium |

| | |
|---|--|
| If your Adjusted Protective Supervision Score is: | Then your Protective Supervision Support Level is: |
| 1-2 | Low |
| 0 | None |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5100, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5120 What is the DDD caregiver status acuity scale? The DDD caregiver status acuity scale is an assessment of risks associated with your caregiver's ability to provide care.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5120, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5140 How is information in the DDD caregiver status acuity scale used by DDD? (1) Information obtained in the DDD caregiver status acuity scale is one of the factors used by DDD to determine the amount of waiver respite, if any, that you are authorized to receive.

(2) The DDD caregiver status acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessment; and

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5140, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5160 When is a collateral contact an informal caregiver? A collateral contact is an informal caregiver when the person provides you supports without payment from DDD for a service.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5160, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5180 When is a collateral contact a formal caregiver? A collateral contact is a formal caregiver when the person receives payment from DDD to provide you a service.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5180, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5200 When is a collateral contact a backup caregiver? A collateral contact is only a backup caregiver when:

- (1) He or she has been identified as an informal caregiver; and
- (2) He or she is available to provide assistance as an informal caregiver when other caregivers are unavailable.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5200, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5220 Are you allowed to identify more than one person as a backup caregiver? There are no limitations regarding the number of persons you are allowed to identify as backup caregivers.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5220, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5240 Who is your primary caregiver? Your primary caregiver is the formal or informal caregiver who provides you with the most support.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5240, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5260 What questions are asked in the DDD caregiver status acuity scale and how are your caregiver's answers scored? The DDD caregiver status acuity scale consists of six questions that must be answered by your primary caregiver. Scores for each question are determined based on your primary caregiver's response for each question.

(1) Overall, how stressed do you feel in caring for the client?

| Answers | Score |
|-------------------|-------|
| Not stressed | 0 |
| Somewhat stressed | 4 |
| Very stressed | 9 |

(2) Other care giving for persons who are disabled, seriously ill, or under age 5?

| Answers | Score |
|--|-------|
| Client is the only person who requires direct care | 0 |

WAC 388-828-5280 Which caregiver risk factors determine the caregiver risk level? The following criteria are used to determine a caregiver's risk level:

| If the following criteria are met: | Then your caregiver risk factor (s) are: |
|--|--|
| (1) You have a score of "less than 1 month" for question 6 ("How long do you expect to continue providing care?") in WAC 388-828-5260. | Immediate risk of loss of caregiver |
| (2) You have not identified any collateral contacts in the CARE system as having a contact role of "informal caregiver;" and (3) You have not identified any collateral contacts in the CARE system as having a contact role of "formal caregiver;" and (4) You have not identified any collateral contacts in the CARE system as having a contact role of "backup caregiver;" and (5) You do not have a paid provider, authorized by DDD, to provide supports for a DDD paid service; and (6) You have an adjusted protective supervision score of 3 or more in WAC 388-828-5080. | No caregiver, and needs one |

| Answers | Score |
|---|-------|
| Part-time responsibility for one or more additional persons | 1 |
| Full-time responsibility for one additional person | 2 |
| Full-time responsibility for two or more additional persons | 4 |

(3) Factors that make it hard to be a caregiver for client?

| Answers | Score |
|---|-------|
| Decline in physical health | 1 |
| Decline in emotional health | 1 |
| Negative impact on employment | 1 |
| Getting less than 5 hours of uninterrupted sleep because of care giving | 1 |
| Health or safety impact | 1 |
| Other issues than impact care giving | 1 |

(4) How much do these things impact your ability to care for the client?

| Answers | Score |
|---------------------------------------|-------|
| Little or no impact | 0 |
| Possible impact, no concrete evidence | 1 |
| Concrete evidence of reduced care | 4 |
| Unable | 9 |

(5) Is the client creating significant stress on other household members?

| Answers | Score |
|--------------------------------------|-------|
| Stable and healthy | 0 |
| Clearly identifiable signs of stress | 4 |
| Serious risk of failure | 9 |

(6) How long do you expect to continue providing care?

| Answers | Score |
|---------------------|-------|
| 2 or more years | 0 |
| 6 months to 2 years | 0 |
| 1 to 6 months | 4 |
| Less than 1 month | 9 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5260, filed 4/23/07, effective 6/1/07.]

| | |
|--|---|
| If the following criteria are met: (7) You have identified one of your collateral contacts in the CARE system as having a contact role of primary caregiver; and (8) Your primary caregiver is 70 years of age or older; and (9) Your primary caregiver lives with you in the same residence. | Then your caregiver risk factor (s) are: Aging caregiver |
|--|---|

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5280, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5300 How does DDD determine a caregiver risk level? (1) The following table reflects the criteria that are used to calculate the caregiver risk level score:

| Your scores for the following questions in WAC 388-828-5240 | | | Your Care-giver Risk Level |
|---|---------------------------|---------------------------|----------------------------|
| Your score for question 4 | Your score for question 5 | Your score for question 6 | |
| 0 | 0 | 0 | None |
| 0 | 0 | 4 | Medium |
| 0 | 0 | 9 | Immediate |
| 0 | 4 | 0 | Medium |
| 0 | 4 | 4 | Medium |
| 0 | 4 | 9 | Immediate |
| 0 | 9 | 0 | High |
| 0 | 9 | 4 | High |
| 0 | 9 | 9 | Immediate |
| 1 | 0 | 0 | Low |
| 1 | 0 | 4 | Medium |
| 1 | 0 | 9 | Immediate |
| 1 | 4 | 0 | Medium |
| 1 | 4 | 4 | Medium |
| 1 | 4 | 9 | Immediate |
| 1 | 9 | 0 | High |
| 1 | 9 | 4 | High |
| 1 | 9 | 9 | Immediate |
| 4 | 0 | 0 | Medium |
| 4 | 0 | 4 | Medium |
| 4 | 0 | 9 | Immediate |
| 4 | 4 | 0 | Medium |
| 4 | 4 | 4 | Medium |
| 4 | 4 | 9 | Immediate |
| 4 | 9 | 0 | High |
| 4 | 9 | 4 | High |
| 4 | 9 | 9 | Immediate |
| 9 | 0 | 0 | High |
| 9 | 0 | 4 | High |
| 9 | 0 | 9 | Immediate |
| 9 | 4 | 0 | High |
| 9 | 4 | 4 | High |
| 9 | 4 | 9 | Immediate |
| 9 | 9 | 0 | High |
| 9 | 9 | 4 | High |
| 9 | 9 | 9 | Immediate |

(2) If your maximum scores for questions four, five, and six are four or less and you have an "Aging caregiver" risk factor in WAC 388-828-5280, your caregiver risk level is medium.

(3) If your caregiver risk factor is "No caregiver, and needs one" in WAC 388-828-5280, your caregiver risk level is immediate regardless of your scores for questions four, five, and six.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5300, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5320 How does DDD determine the availability of a backup caregiver? DDD's determination of availability of a back up caregiver is based on the responses of you and your respondent(s) to the following question:

(1) Under what conditions are other caregivers available?

| Answers available for selection | Score |
|---------------------------------|-------|
| Routinely provides care | 0 |
| Upon request | 2 |
| Emergency only | 4 |
| No other caregiver available | 9 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5320, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5340 How does DDD determine whether a backup caregiver lives with you? You or your respondent identifies that your backup caregiver(s) lives with you.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5340, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5360 How does DDD determine the risk level score of your backup caregiver not being able to provide the supports you need when you need them? The following table identifies the criteria that are used to calculate the risk level score of your backup caregiver not being able to provide the supports you need when you need them:

| | |
|---|--|
| If the availability of your back caregiver is: (1) Your backup caregivers are available routinely or upon request as evidenced by a score of 0 to 2 for question 1 of the backup caregiver subscale; and (2) You have a person identified as a backup caregiver that does not live with you evidenced by the "Lives with client" checkbox not being selected as contact details information for him or her. | Then your risk level score is: 1 (Not at risk) |
|---|--|

| | |
|--|--------------------------------|
| If the availability of your back caregiver is: | Then your risk level score is: |
| (3) Your backup caregivers are available upon an emergency only basis evidenced by a score of 4 for question 1 of the backup caregiver subscale; and (4) "Lives with client" has been selected for all of the persons you have identified as your backup caregivers. | 2 (Some risk) |
| (5) You have no other caregiver available evidenced by a score of 9 for question 1 of the backup caregiver subscale. | 3 (High risk) |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5360, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5380 What is the DDD activities of daily living (ADL) acuity scale? The DDD activities of daily living acuity scale is an algorithm that determines your ADL support needs level.

(1) The DDD activities of daily living acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessments; and

(2) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5380, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5400 What does the activities of daily living (ADL) acuity scale measure? The DDD ADL acuity scale measures:

(1) Your ADL support needs level from the support assessment for children if you are age birth through fifteen years old; or

(2) Your ADL support needs level from the SIS assessment if you are age sixteen or older.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5400, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5420 How does DDD determine your ADL support needs score if you are age birth through fifteen? If you are a child age birth through fifteen, your ADL support needs score is the total of your acuity scores for each of the following ADL questions in the support assessment for children:

| ADL questions from the Support Assessment for Children in WAC 388-828-3040 | |
|--|------------------------|
| Question # | Text of ADL Questions: |
| 1 | Dress and Groom self |
| 2 | Toilet self |
| 3 | Eat at age level |
| 4 | Move around |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5420, filed 4/23/07, effective 6/1/07.]

| SIS ADL Questions | Text of SIS ADL Questions | If your "Frequency of Support" score is: | And your "Type of Support" score is: | Then your adjusted "Type of Support" score is: |
|-------------------|--|--|--------------------------------------|--|
| A1 | Using the toilet | 3 | 3 | 3 |
| A4 | Eating food | 1 | 2 | 0 |
| A6 | Dressing | 3 | 3 | 3 |
| A7 | Bathing and taking care of personal hygiene and grooming needs | 1 | 2 | 0 |

WAC 388-828-5440 How does DDD use your ADL support needs score for the support assessment for children? (1) DDD uses your ADL support needs score and the following table to determine your ADL support needs level for the support assessment for children:

| If your ADL support needs score is: | Then your ADL support need level is: | Value |
|-------------------------------------|--------------------------------------|-------|
| 11 to 16 | High | 3 |
| 7 to 10 | Medium | 2 |
| 2 to 6 | Low | 1 |
| 0 or 1 | None | 0 |

(2) If your acuity score is four for any of the ADL questions in WAC 388-828-3040, your ADL support needs level is determined to be high.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5440, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5460 How does DDD determine your ADL support needs score if you are age sixteen or older?

(1) If you are age sixteen or older, your ADL support needs score is the total adjusted "Type of support" scores from the following SIS questions:

| ADL questions from the SIS assessment in WAC 388-828-4200 and 388-828-4280 | |
|--|--|
| Question # | Text of ADL questions: |
| A1 | Using the toilet |
| A4 | Eating food |
| A6 | Dressing |
| A7 | Bathing and taking care of personal hygiene and grooming needs |
| E1 | Taking medications |
| E4 | Ambulating and moving about |

(2) If your "Frequency of support" score for a SIS ADL question is zero or one, adjust your "Type of support" score for that question to zero.

(3) If your "Frequency of support" score for a SIS ADL support question is two, three, or four, no adjustment is needed to your "Type of support" score.

Example:

| SIS ADL Questions | Text of SIS ADL Questions | If your "Frequency of Support" score is: | And your "Type of Support" score is: | Then your adjusted "Type of Support" score is: |
|-----------------------------------|-----------------------------|--|--------------------------------------|--|
| E1 | Taking medications | 3 | 2 | 2 |
| E4 | Ambulating and moving about | 0 | 0 | 0 |
| Your SIS ADL support needs score: | | | | 8 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5460, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5480 How does DDD determine your ADL support needs level for the SIS assessment? (1) DDD uses your ADL support needs score and the following table to determine your ADL support needs level for the SIS assessment if you are age sixteen or older:

| If the sum of your adjusted ADL support needs score for the SIS is: | Then your ADL support needs level for the SIS is: | Value |
|---|---|-------|
| 16 to 24 | High | 3 |
| 10 to 15 | Medium | 2 |
| 2 to 9 | Low | 1 |
| 0 or 1 | None | 0 |

(2) If you have a "Type of support" score of four for any of the questions listed in WAC 388-828-5460, your ADL support needs level for the SIS assessment is determined to be high.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5480, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5500 What is the DDD behavioral acuity scale? The DDD behavioral acuity scale is an assessment of your behavioral support needs based on your scores from the SIS exceptional behavior scale.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5500, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5520 How is information in the DDD behavioral acuity scale used by DDD? (1) Information obtained in the DDD behavioral acuity scale is one of the factors used by DDD to determine the amount of waiver respite, if any, that you are authorized to receive.

(2) The DDD behavioral acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessment.

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5520, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5540 How does DDD determine if you have a prominent behavior? You are determined to have a prominent behavior when a question in WAC 388-828-4380 has a support score of one or two.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5540, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5560 Do all prominent behaviors get scored? If you have two or more prominent behaviors, DDD will ask you and your respondent(s) for input and must select

only one behavior to be scored as your most prominent behavior.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5560, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5580 How does DDD determine the frequency of your most prominent behavior? If you have a prominent behavior, DDD asks you and your respondent(s) to identify the frequency of occurrence of your most prominent behavior using the following table:

| If the frequency of occurrence of your most prominent behavior is: | Then your score for frequency is: |
|--|-----------------------------------|
| Less than once per month | Rare |
| 1 to 3 times per month | Occasional |
| 1 to 4 times per week | Occasional |
| 1 to 3 times daily | Frequent |
| 4 or more times daily | Frequent |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5580, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5600 How does DDD determine the severity of your most prominent behavior? If you have a prominent behavior, DDD asks you and your respondent(s) to identify the severity of your most prominent behavior using the following table:

| If the characteristics of your most prominent behavior are: | Then your score for severity is: |
|---|----------------------------------|
| Your behavior may be uncooperative, inconvenient, repetitive, and/or require time intensive support. However, your behavior is not considered aggressive or self-injurious. | Minor incidents |
| Your behavior, if allowed to continue over time, may result in life-threatening harm for yourself and/or others. | Potentially dangerous |
| Your behavior without immediate intervention will result in life-threatening harm for yourself and/or others. | Life threatening |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5600, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5620 How does DDD determine the type of caregiver assistance you receive to help you keep your most prominent behavior under control? DDD asks you and your respondent(s) to identify the type of caregiver assistance you receive to help you keep your most prominent behavior under control using the following table:

| | |
|--|--|
| If the caregiver assistance provided to support your most prominent behavior is: | Then your score for caregiver assistance is: |
| Your respondent reports that you do not require any assistance to keep your most prominent behavior under control. | No supervision, Oversight |
| Your respondent reports that you may at times require supervision and verbal redirection to keep your most prominent behavior under control. | Verbal redirection |
| Your respondent reports that you require occasional physical guidance of limbs and/or caregiver intervention to keep your most prominent behavior under control. | Occasional physical guiding or intervention |

| | |
|--|--|
| If the caregiver assistance provided to support your most prominent behavior is: | Then your score for caregiver assistance is: |
| Your respondent reports that you require in-sight supervision at all times and may require 1 to 2 person physical restraint or removal from the area to keep your most prominent behavior under control. | In-Sight Supervision -Physical restraint |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5620, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5640 How does DDD determine your behavioral acuity level? DDD uses your frequency, severity, and caregiver assistance scores to determine your behavioral acuity level using the following table:

| If your score for frequency is: | And your score for severity is: | And your score for caregiver assistance is: | Then your behavioral acuity level is: | |
|---------------------------------|---------------------------------|---|---------------------------------------|--------|
| Rare | Minor | None | Low | |
| | | Verbal redirection | Low | |
| | | Physical guiding or selection | Low | |
| | | Physical restraint | Low | |
| | Potentially Dangerous | None | Low | |
| | | Verbal redirection | Low | |
| | | Physical guiding or selection | Medium | |
| | | Physical restraint | High | |
| | | Life-Threatening | None | Medium |
| | | | Verbal redirection | Medium |
| | Physical guiding or selection | | High | |
| | Physical restraint | | High | |
| Occasional | Minor | None | Low | |
| | | Verbal redirection | Low | |
| | | Physical guiding or selection | Low | |
| | | Physical restraint | Medium | |
| | Potentially Dangerous | None | Medium | |
| | | Verbal redirection | Medium | |
| | | Physical guiding or selection | Medium | |
| | | Physical restraint | High | |
| | | Life Threatening | None | Medium |
| | | | Verbal redirection | Medium |
| | Physical guiding or selection | | High | |
| | Physical restraint | | High | |
| Frequent | Minor | None | Low | |
| | | Verbal redirection | Low | |
| | | Physical guiding or selection | Medium | |
| | | Physical restraint | Medium | |
| | Potentially Dangerous | None | Medium | |
| | | Verbal redirection | Medium | |
| | | Physical guiding or selection | High | |
| | | Physical restraint | High | |
| | | Life-Threatening | None | High |
| | | | Verbal redirection | High |
| | Physical guiding or selection | | High | |
| | Physical restraint | | High | |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5640, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5660 What is the DDD medical acuity scale? The DDD medical acuity scale is an algorithm that determines your medical support needs level.

(1) The DDD medical acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessments; and

(2) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5660, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5680 What is the purpose of the DDD medical acuity scale? The purpose of the DDD medical acuity scale is to determine your medical acuity level.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5680, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5700 How does DDD determine your medical acuity level? DDD uses your SIS support scores to questions in the exceptional medical support needs scale per WAC 388-828-4360 and the following table to determine your medical acuity level:

| If you meet the following criteria: | Then your medical acuity level is: | Value |
|---|------------------------------------|-------|
| (1) If you have a score of 2 on questions 1, 4, and 7; | High | 3 |
| (2) If you have a score of 2 on any two of the following questions: 2, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 16, or 17; | High | 3 |
| (3) If your total exceptional medical support needs score is 8 or higher; | High | 3 |
| (4) If you have a score of 2 on any of the following questions: 2, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 16, or 17 and do not meet the criteria for a high medical acuity level; | Medium | 2 |
| (5) If your total exceptional medical support needs score is 6 or 7 and you do not meet the criteria for a high medical acuity level; | Medium | 2 |
| (6) If your total exceptional medical support needs score is 5 or less, but greater than zero, and you do not have a score of 2 on any questions excluding number 15; | Low | 1 |
| (7) If your total exceptional medical support needs score equals zero. | None | 0 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5700, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5720 What is the DDD interpersonal support acuity scale? The DDD interpersonal support acuity scale is an algorithm that measures your ability to interact with others in a variety of settings and determines your interpersonal support needs level.

(1) The DDD interpersonal support acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessments; and

(2) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5720, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5740 What does the DDD interpersonal support acuity scale determine? The DDD interpersonal support acuity scale determines:

(1) Your interpersonal support acuity level from the support assessment for children if you are age birth through fifteen; or

(2) Your interpersonal support acuity level from the SIS assessment if you are age sixteen or older.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5740, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5760 How does DDD determine your interpersonal support needs score if you are age birth through fifteen? If you are a child age birth through fifteen, your interpersonal support needs score is the total of your acuity scores for each of the following questions in the support assessment for children:

| Interpersonal support needs questions from the support assessment for children in WAC 388-828-3040 | |
|--|---|
| Question # | Text of Questions: |
| 5 | Communicate: What support does the child need to communicate with others of same age? |

| Interpersonal support needs questions from the support assessment for children in WAC 388-828-3040 | |
|--|---|
| 11 | Have relationships with family members: What support does the child need to make the kind of relationships with family members expected of non disabled children of the same age? |
| 13 | Play with others: What supports are needed for the child to develop age-level skills in playing with others? |
| 17 | Effectively relate to other students/peers: What support does the person need to most effectively relate to fellow students and/or peers? |
| 18 | Have behaviors which promote being included: What support is needed for this person to have behaviors which promote being included? |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5760, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5780 What does the DDD interpersonal support needs score determine if you are age birth through fifteen? If you are age birth through fifteen, DDD uses your interpersonal support needs score and the following table to determine your interpersonal support needs level:

| If your interpersonal support needs score is: | Then your interpersonal support needs level is: | Value |
|---|---|-------|
| (1) Your interpersonal support needs score is 10 or more. | High | 3 |

| If your interpersonal support needs score is: | Then your interpersonal support needs level is: | Value |
|--|---|-------|
| (2) Your interpersonal support needs score is a 4, 5, 6, 7, 8, or 9; or (3) You have an acuity score of 3 or 4 for one of the interpersonal support needs questions listed in WAC 388-828-3040. | Medium | 2 |
| (4) Your interpersonal support needs score is 1, 2, or 3; and (5) You do not have an acuity score of 3 or 4 for one of the interpersonal support needs questions listed in WAC 388-828-3040. | Low | 1 |
| (6) Your interpersonal support needs score is zero. | None | 0 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5780, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5800 How does DDD determine your interpersonal support needs score if you are age sixteen or older? If you are age sixteen or older, your interpersonal support needs score is determined by adding your raw scores to the following SIS questions:

| Interpersonal support needs questions from the SIS assessment | |
|---|---|
| Question # | Text of interpersonal support needs questions: |
| B7 | Interacting with community members |
| C1 | Interacting with others in learning activities |
| D3 | Interacting with co-workers |
| D4 | Interacting with supervisors/coaches |
| D8 | Seeking information and assistance from an employer |
| F1 | Socializing within the household |
| F3 | Socializing outside the household |
| F5 | Communicating with others about personal needs |
| F6 | Using appropriate social skills |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5800, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5820 How does DDD use your interpersonal support needs score if you are age sixteen or older? If you are age sixteen or older, DDD uses your interpersonal support needs score and the following table to determine your interpersonal support needs level:

| If your interpersonal support needs score is: | Then your interpersonal support needs level is: | Value |
|---|---|-------|
| (1) 56 or more | High | 3 |
| (2) At least 20; and (3) Less than 56 | Medium | 2 |

| If your interpersonal support needs score is: | Then your interpersonal support needs level is: | Value |
|--|---|-------|
| (4) 3 or 4 for both "Type of Support" and "Frequency of Support" for one of the interpersonal support needs questions | Medium | 2 |
| (5) At least 1; and (6) Less than 20; and (7) You do not have a score of 3 or 4 for both "Type of Support" and "Frequency of Support" for one of the interpersonal support needs questions | Low | 1 |
| (8) Zero | None | 0 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5820, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5840 What is the DDD mobility acuity scale? The DDD mobility acuity scale is an algorithm that measures your ability to ambulate and move around.

(1) The DDD mobility acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessments; and

(2) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5840, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5860 What does the DDD mobility acuity scale determine? The DDD mobility acuity scale determines:

(1) Your mobility acuity level from the support assessment for children if you are age birth through fifteen; or

(2) Your mobility acuity level from the SIS assessment if you are age sixteen or older.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5860, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5880 How does DDD determine your mobility acuity level if you are age birth through fifteen? If you are age birth through fifteen, your mobility acuity level is determined by your acuity score to question four of the ICF/MR level of care assessment in WAC 388-828-3040 using the following table:

| If your acuity score for question 4 is: | Then your mobility acuity level is: |
|---|-------------------------------------|
| 4 | High |
| 3 | Medium |
| 1 or 2 | Low |
| 0 | None |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5880, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5900 How does DDD determine your mobility acuity level if you are age sixteen or older? If you are age sixteen or older, your mobility acuity level is deter-

mined by your scores to question E4 "Ambulating and moving about" in WAC 388-828-4280 using the following table:

| If you score for "Frequency of Support" is: | And your score for "Type of Support" is: | Then your Mobility Acuity Level is: | Value |
|--|--|-------------------------------------|-------|
| 3 or 4 | 4 | High | 3 |
| 3 or 4 | 3 | Medium | 2 |
| If your raw score for question E4 or 5 or more and you do not meet the criteria for a high or medium mobility acuity level | | Low | 1 |
| If your raw score for question E4 is 4 or less | | None | 0 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5900, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5920 What is the respite assessment?

The respite assessment is an algorithm in the DDD assessment that determines the number of hours of respite care, if any, that your provider may receive per year if DDD has authorized you to receive Basic, Basic Plus, or Core waiver services per chapter 388-845 WAC.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5920, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5940 Are there any exceptions when the respite assessment is not used to determine the number of hours for waiver respite services? The respite assessment is not used to determine waiver respite when you are receiving any of the following:

(1) Voluntary placement program services per chapter 388-826 WAC; or

(2) Companion home services per chapter 388-821 WAC.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5940, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5960 What is the purpose of the respite assessment? The purpose of the respite assessment is to determine your respite assessment level using your scores from:

- (1) The protective supervision acuity scale;
- (2) The DDD caregiver status acuity scale; and
- (3) The DDD behavioral acuity scale.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5960, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5980 How does DDD determine your respite assessment level? (1) DDD determines your respite assessment level using the following table:

| If your Protective Supervision Support Level is: | And your primary caregiver risk level is: | And your backup caregiver risk score is: | And your behavioral acuity level is: | Then your respite assessment level is: |
|--|---|--|--------------------------------------|--|
| 0 | None | 1 | None | 1 |
| 0 | None | 1 | Low | 1 |
| 0 | None | 1 | Medium | 1 |
| 0 | None | 1 | High | 2 |
| 0 | None | 2 or 3 | None | 1 |
| 0 | None | 2 or 3 | Low | 1 |
| 0 | None | 2 or 3 | Medium | 2 |
| 0 | None | 2 or 3 | High | 2 |
| 0 | Low | 1 | None | 1 |
| 0 | Low | 1 | Low | 1 |
| 0 | Low | 1 | Medium | 1 |
| 0 | Low | 1 | High | 2 |
| 0 | Low | 2 or 3 | None | 1 |
| 0 | Low | 2 or 3 | Low | 1 |
| 0 | Low | 2 or 3 | Medium | 2 |
| 0 | Low | 2 or 3 | High | 2 |
| 0 | Medium | 1 | None | 1 |
| 0 | Medium | 1 | Low | 1 |
| 0 | Medium | 1 | Medium | 1 |
| 0 | Medium | 1 | High | 2 |
| 0 | Medium | 2 or 3 | None | 1 |
| 0 | Medium | 2 or 3 | Low | 1 |
| 0 | Medium | 2 or 3 | Medium | 2 |
| 0 | Medium | 2 or 3 | High | 2 |
| 0 | High | 1 | None | 1 |
| 0 | High | 1 | Low | 1 |
| 0 | High | 1 | Medium | 2 |
| 0 | High | 1 | High | 2 |
| 0 | High | 2 or 3 | None | 2 |
| 0 | High | 2 or 3 | Low | 2 |
| 0 | High | 2 or 3 | Medium | 2 |

| If your Protective Supervision Support Level is: | And your primary caregiver risk level is: | And your backup caregiver risk score is: | And your behavioral acuity level is: | Then your respite assessment level is: |
|--|---|--|--------------------------------------|--|
| 0 | High | 2 or 3 | High | 3 |
| 0 | Immediate | 1 | None | 1 |
| 0 | Immediate | 1 | Low | 1 |
| 0 | Immediate | 1 | Medium | 2 |
| 0 | Immediate | 1 | High | 2 |
| 0 | Immediate | 2 or 3 | None | 2 |
| 0 | Immediate | 2 or 3 | Low | 2 |
| 0 | Immediate | 2 or 3 | Medium | 2 |
| 0 | Immediate | 2 or 3 | High | 3 |
| 1 | None | 1 | None | 1 |
| 1 | None | 1 | Low | 1 |
| 1 | None | 1 | Medium | 1 |
| 1 | None | 1 | High | 2 |
| 1 | None | 2 or 3 | None | 1 |
| 1 | None | 2 or 3 | Low | 1 |
| 1 | None | 2 or 3 | Medium | 2 |
| 1 | None | 2 or 3 | High | 3 |
| 1 | Low | 1 | None | 1 |
| 1 | Low | 1 | Low | 1 |
| 1 | Low | 1 | Medium | 1 |
| 1 | Low | 1 | High | 2 |
| 1 | Low | 2 or 3 | None | 1 |
| 1 | Low | 2 or 3 | Low | 1 |
| 1 | Low | 2 or 3 | Medium | 2 |
| 1 | Low | 2 or 3 | High | 3 |
| 1 | Medium | 1 | None | 1 |
| 1 | Medium | 1 | Low | 1 |
| 1 | Medium | 1 | Medium | 2 |
| 1 | Medium | 1 | High | 3 |
| 1 | Medium | 2 or 3 | None | 1 |
| 1 | Medium | 2 or 3 | Low | 2 |
| 1 | Medium | 2 or 3 | Medium | 2 |
| 1 | Medium | 2 or 3 | High | 3 |
| 1 | High | 1 | None | 2 |
| 1 | High | 1 | Low | 2 |
| 1 | High | 1 | Medium | 2 |
| 1 | High | 1 | High | 3 |
| 1 | High | 2 or 3 | None | 2 |
| 1 | High | 2 or 3 | Low | 2 |
| 1 | High | 2 or 3 | Medium | 3 |
| 1 | High | 2 or 3 | High | 4 |
| 1 | Immediate | 1 | None | 2 |
| 1 | Immediate | 1 | Low | 2 |
| 1 | Immediate | 1 | Medium | 2 |
| 1 | Immediate | 1 | High | 3 |
| 1 | Immediate | 2 or 3 | None | 2 |
| 1 | Immediate | 2 or 3 | Low | 2 |
| 1 | Immediate | 2 or 3 | Medium | 3 |
| 1 | Immediate | 2 or 3 | High | 4 |
| 2 or 3 | None | 1 | None | 1 |
| 2 or 3 | None | 1 | Low | 1 |
| 2 or 3 | None | 1 | Medium | 2 |
| 2 or 3 | None | 1 | High | 3 |
| 2 or 3 | None | 2 or 3 | None | 2 |
| 2 or 3 | None | 2 or 3 | Low | 2 |
| 2 or 3 | None | 2 or 3 | Medium | 2 |
| 2 or 3 | None | 2 or 3 | High | 4 |
| 2 or 3 | Low | 1 | None | 1 |

| If your Protective Supervision Support Level is: | And your primary caregiver risk level is: | And your backup caregiver risk score is: | And your behavioral acuity level is: | Then your respite assessment level is: |
|--|---|--|--------------------------------------|--|
| 2 or 3 | Low | 1 | Low | 1 |
| 2 or 3 | Low | 1 | Medium | 2 |
| 2 or 3 | Low | 1 | High | 3 |
| 2 or 3 | Low | 2 or 3 | None | 2 |
| 2 or 3 | Low | 2 or 3 | Low | 2 |
| 2 or 3 | Low | 2 or 3 | Medium | 2 |
| 2 or 3 | Low | 2 or 3 | High | 4 |
| 2 or 3 | Medium | 1 | None | 2 |
| 2 or 3 | Medium | 1 | Low | 2 |
| 2 or 3 | Medium | 1 | Medium | 2 |
| 2 or 3 | Medium | 1 | High | 3 |
| 2 or 3 | Medium | 2 or 3 | None | 2 |
| 2 or 3 | Medium | 2 or 3 | Low | 2 |
| 2 or 3 | Medium | 2 or 3 | Medium | 3 |
| 2 or 3 | Medium | 2 or 3 | High | 4 |
| 2 or 3 | High | 1 | None | 2 |
| 2 or 3 | High | 1 | Low | 2 |
| 2 or 3 | High | 1 | Medium | 2 |
| 2 or 3 | High | 1 | High | 3 |
| 2 or 3 | High | 2 or 3 | None | 2 |
| 2 or 3 | High | 2 or 3 | Low | 2 |
| 2 or 3 | High | 2 or 3 | Medium | 3 |
| 2 or 3 | High | 2 or 3 | High | 4 |
| 2 or 3 | Immediate | 1 | None | 2 |
| 2 or 3 | Immediate | 1 | Low | 2 |
| 2 or 3 | Immediate | 1 | Medium | 2 |
| 2 or 3 | Immediate | 1 | High | 3 |
| 2 or 3 | Immediate | 2 or 3 | None | 2 |
| 2 or 3 | Immediate | 2 or 3 | Low | 2 |
| 2 or 3 | Immediate | 2 or 3 | Medium | 3 |
| 2 or 3 | Immediate | 2 or 3 | High | 4 |
| 4 | None | 1 | None | 2 |
| 4 | None | 1 | Low | 2 |
| 4 | None | 1 | Medium | 2 |
| 4 | None | 1 | High | 3 |
| 4 | None | 2 or 3 | None | 2 |
| 4 | None | 2 or 3 | Low | 2 |
| 4 | None | 2 or 3 | Medium | 3 |
| 4 | None | 2 or 3 | High | 4 |
| 4 | Low | 1 | None | 2 |
| 4 | Low | 1 | Low | 2 |
| 4 | Low | 1 | Medium | 2 |
| 4 | Low | 1 | High | 3 |
| 4 | Low | 2 or 3 | None | 2 |
| 4 | Low | 2 or 3 | Low | 2 |
| 4 | Low | 2 or 3 | Medium | 3 |
| 4 | Low | 2 or 3 | High | 4 |
| 4 | Medium | 1 | None | 2 |
| 4 | Medium | 1 | Low | 2 |
| 4 | Medium | 1 | Medium | 3 |
| 4 | Medium | 1 | High | 3 |
| 4 | Medium | 2 or 3 | None | 2 |
| 4 | Medium | 2 or 3 | Low | 3 |
| 4 | Medium | 2 or 3 | Medium | 3 |
| 4 | Medium | 2 or 3 | High | 4 |
| 4 | High | 1 | None | 2 |
| 4 | High | 1 | Low | 2 |
| 4 | High | 1 | Medium | 3 |

| If your Protective Supervision Support Level is: | And your primary caregiver risk level is: | And your backup caregiver risk score is: | And your behavioral acuity level is: | Then your respite assessment level is: |
|--|---|--|--------------------------------------|--|
| 4 | High | 1 | High | 3 |
| 4 | High | 2 or 3 | None | 2 |
| 4 | High | 2 or 3 | Low | 3 |
| 4 | High | 2 or 3 | Medium | 4 |
| 4 | High | 2 or 3 | High | 4 |
| 4 | Immediate | 1 | None | 2 |
| 4 | Immediate | 1 | Low | 2 |
| 4 | Immediate | 1 | Medium | 3 |
| 4 | Immediate | 1 | High | 3 |
| 4 | Immediate | 2 or 3 | None | 2 |
| 4 | Immediate | 2 or 3 | Low | 3 |
| 4 | Immediate | 2 or 3 | Medium | 4 |
| 4 | Immediate | 2 or 3 | High | 4 |
| 5 | None | 1 | None | 2 |
| 5 | None | 1 | Low | 2 |
| 5 | None | 1 | Medium | 3 |
| 5 | None | 1 | High | 4 |
| 5 | None | 2 or 3 | None | 3 |
| 5 | None | 2 or 3 | Low | 3 |
| 5 | None | 2 or 3 | Medium | 4 |
| 5 | None | 2 or 3 | High | 5 |
| 5 | Low | 1 | None | 2 |
| 5 | Low | 1 | Low | 2 |
| 5 | Low | 1 | Medium | 3 |
| 5 | Low | 1 | High | 4 |
| 5 | Low | 2 or 3 | None | 3 |
| 5 | Low | 2 or 3 | Low | 3 |
| 5 | Low | 2 or 3 | Medium | 4 |
| 5 | Low | 2 or 3 | High | 5 |
| 5 | Medium | 1 | None | 2 |
| 5 | Medium | 1 | Low | 2 |
| 5 | Medium | 1 | Medium | 3 |
| 5 | Medium | 1 | High | 4 |
| 5 | Medium | 2 or 3 | None | 3 |
| 5 | Medium | 2 or 3 | Low | 3 |
| 5 | Medium | 2 or 3 | Medium | 4 |
| 5 | Medium | 2 or 3 | High | 5 |
| 5 | High | 1 | None | 2 |
| 5 | High | 1 | Low | 2 |
| 5 | High | 1 | Medium | 3 |
| 5 | High | 1 | High | 4 |
| 5 | High | 2 or 3 | None | 3 |
| 5 | High | 2 or 3 | Low | 3 |
| 5 | High | 2 or 3 | Medium | 4 |
| 5 | High | 2 or 3 | High | 5 |
| 5 | Immediate | 1 | None | 2 |
| 5 | Immediate | 1 | Low | 2 |
| 5 | Immediate | 1 | Medium | 3 |
| 5 | Immediate | 1 | High | 4 |
| 5 | Immediate | 2 or 3 | None | 3 |
| 5 | Immediate | 2 or 3 | Low | 3 |
| 5 | Immediate | 2 or 3 | Medium | 4 |
| 5 | Immediate | 2 or 3 | High | 5 |
| 6 | None | 1 | None | 2 |
| 6 | None | 1 | Low | 3 |
| 6 | None | 1 | Medium | 3 |
| 6 | None | 1 | High | 4 |
| 6 | None | 2 or 3 | None | 3 |

| If your Protective Supervision Support Level is: | And your primary caregiver risk level is: | And your backup caregiver risk score is: | And your behavioral acuity level is: | Then your respite assessment level is: |
|--|---|--|--------------------------------------|--|
| 6 | None | 2 or 3 | Low | 3 |
| 6 | None | 2 or 3 | Medium | 4 |
| 6 | None | 2 or 3 | High | 5 |
| 6 | Low | 1 | None | 2 |
| 6 | Low | 1 | Low | 3 |
| 6 | Low | 1 | Medium | 3 |
| 6 | Low | 1 | High | 4 |
| 6 | Low | 2 or 3 | None | 3 |
| 6 | Low | 2 or 3 | Low | 3 |
| 6 | Low | 2 or 3 | Medium | 4 |
| 6 | Low | 2 or 3 | High | 5 |
| 6 | Medium | 1 | None | 3 |
| 6 | Medium | 1 | Low | 3 |
| 6 | Medium | 1 | Medium | 3 |
| 6 | Medium | 1 | High | 4 |
| 6 | Medium | 2 or 3 | None | 3 |
| 6 | Medium | 2 or 3 | Low | 4 |
| 6 | Medium | 2 or 3 | Medium | 4 |
| 6 | Medium | 2 or 3 | High | 5 |
| 6 | High | 1 | None | 3 |
| 6 | High | 1 | Low | 3 |
| 6 | High | 1 | Medium | 4 |
| 6 | High | 1 | High | 4 |
| 6 | High | 2 or 3 | None | 4 |
| 6 | High | 2 or 3 | Low | 4 |
| 6 | High | 2 or 3 | Medium | 5 |
| 6 | High | 2 or 3 | High | 5 |
| 6 | Immediate | 1 | None | 3 |
| 6 | Immediate | 1 | Low | 3 |
| 6 | Immediate | 1 | Medium | 4 |
| 6 | Immediate | 1 | High | 4 |
| 6 | Immediate | 2 or 3 | None | 4 |
| 6 | Immediate | 2 or 3 | Low | 4 |
| 6 | Immediate | 2 or 3 | Medium | 5 |
| 6 | Immediate | 2 or 3 | High | 5 |

(2) DDD adds one level to your respite assessment level when your respite assessment level is determined to be a one, two, three, or four and you have a score of four for question two "Other caregiving for persons who are disabled, seriously ill, or under five" in the DDD caregiver status acuity scale. See WAC 388-828-5260.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-5980, filed 4/23/07, effective 6/1/07.]

WAC 388-828-6000 How does DDD determine the maximum number of hours you may receive for respite care? The maximum number of hours you may receive per year is determined by using the following table:

| If your respite assessment level is: | Then the maximum number of hours you may receive for respite care each year is: |
|--------------------------------------|---|
| 1 | 240 |
| 2 | 240 |
| 3 | 336 |
| 4 | 432 |
| 5 | 528 |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-6000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-6020 What is the purpose of the programs and services component? The purpose of the programs and services component is to document:

- (1) DDD services you are currently receiving;
- (2) DDD services you have been approved to receive; and
- (3) If you currently meet the ICF/MR level of care requirements for continued DDD HCBS waiver eligibility or for potential DDD HCBS waiver services if resources become available.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-6020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-7000 What is the purpose of the service level assessment module? The purpose of the service level assessment module is to determine a service level and the number of hours you are eligible to receive for Medicaid or waiver personal care services per chapter 388-106 WAC.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-7000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-7020 What components contained in the service level assessment module determine a service level and/or number of hours? The service level assessment module contains two components that are used to determine a service level and/or number of hours for the following:

- (1) The CARE assessment for Medicaid or waiver personal care services, as defined in chapter 388-106 WAC; and
- (2) The DDD seizure acuity scale as defined in WAC 388-828-7040 through 388-828-7080.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-7020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-7040 What is the DDD seizure acuity scale? (1) The DDD seizure acuity scale is an assessment of your seizure support needs.

(2) The DDD seizure acuity scale does not affect service determination for the Medicaid personal care or waiver personal care assessments.

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-7040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-7060 What does the DDD seizure acuity scale measure? The DDD seizure acuity scale is used to measure your seizure acuity level.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-7060, filed 4/23/07, effective 6/1/07.]

WAC 388-828-7080 How does DDD determine your seizure acuity level? DDD uses criteria in the following table to determine your seizure acuity level:

| If you meet the following criteria: | Then your seizure acuity level is: |
|---|------------------------------------|
| (1) You received medical attention for your seizures, on two or more occasions. (2) Medical attention includes: (a) Visits to a primary care physician; (b) Visits to an emergency room; (c) Calls to 911 that result in paramedics having to provide care, treatment, or stabilization services. | High |
| (3) You have convulsive seizures (Tonic-clonic or atonic) and meet the following conditions: (a) You have a seizure at least once every three months; and (b) Your seizures last at least five minutes. | High |
| (4) You have convulsive seizures (Tonic-clonic or atonic) and meet the following conditions: (a) You have a seizure at least once every three months; and (b) Your seizures last less than five minutes. | Medium |

| If you meet the following criteria: | Then your seizure acuity level is: |
|---|------------------------------------|
| (5) You report a history of having seizures and you do not meet the requirements for a high or medium seizure acuity level. | Low |
| (6) You report that you do not have a history of seizures. | None |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-7080, filed 4/23/07, effective 6/1/07.]

WAC 388-828-8000 What is the purpose of the individual support plan (ISP) module? The purpose of the individual support plan module is to create a written plan that includes:

(1) Your acuity scores generated from the support assessment;

(2) Referral information;

(3) The SSP, if any, you are approved to receive in lieu of a DDD paid service; and

(4) DDD paid services you are authorized to receive:

(a) If you are enrolled in a DDD waiver, the ISP must address all the health and welfare needs identified in your ICF/MR level of care assessment and the supports used to meet your assessed needs; or

(b) If you are not enrolled in a DDD waiver, DDD is only required to address the DDD paid services you are approved to receive.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-8000, filed 4/23/07, effective 6/1/07.]

WAC 388-828-8020 What components contained in the individual support plan module determine a service level and/or number of hours? The foster care rate assessment, as defined in chapter 388-826 WAC, is the only component in the individual support plan module that determines a service level and/or number of hours.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-8020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-8040 How does DDD determine which health and welfare needs must be addressed in your individual support plan if you are age birth through fifteen?

If you are age birth through fifteen and are receiving DDD HCBS waiver services or reside in a state only residential setting, DDD uses the following tables to determine the health and welfare needs that must be addressed in your individual support plan:

(1) Activities from the support needs assessment for children:

| # | Questions in the Support Needs Assessment for Children: | DDD must address in your ISP if you have an acuity score of: | Health and Welfare Category |
|----|---|--|-----------------------------|
| 1 | Dress and groom self | 2 or more | Home Living |
| 2 | Toilet self | 2 or more | Home Living |
| 3 | Eat at age level | 3 or more | Home Living |
| 4 | Move around | 3 or more | Home Living |
| 5 | Communicate | 2 or more | Home Living |
| 7 | Make choices and take responsibility | 2 or more | Protection and Advocacy |
| 8 | Explore environment | 3 or more | Community Living |
| 9 | Meet therapy health needs | 1 or more | Medical Supports |
| 10 | Help family continue to meet child's needs | 1 or more | Protection and Advocacy |
| 15 | Identify and respond safely to emergencies | 1 or more | Health and Safety |
| 16 | Practice age-level safety measures | 2 or more | Protection and Advocacy |
| 17 | Effectively relate to other students/peers | 3 or more | Employment |
| 18 | Have behaviors which promote being included | 3 or more | Behavior Supports |

(2) Medical supports from the SIS exceptional medical support needs scale

| # | Questions in the Exceptional Medical Support Needs Scale | DDD must address in your ISP if you have an acuity score of: | Health and Welfare Category |
|----|---|--|-----------------------------|
| 1 | Inhalation or oxygen therapy | 1 or more | Medical Supports |
| 2 | Postural drainage | 1 or more | Medical Supports |
| 3 | Chest PT | 1 or more | Medical Supports |
| 4 | Suctioning | 1 or more | Medical Supports |
| 5 | Oral Stimulation or Jaw Repositioning | 1 or more | Medical Supports |
| 6 | Tube feeding (e.g., nasogastric) | 1 or more | Medical Supports |
| 7 | Parenteral feeding (e.g., IV) | 1 or more | Medical Supports |
| 8 | Turning or positioning | 1 or more | Medical Supports |
| 9 | Dressing of open wound(s) | 1 or more | Medical Supports |
| 10 | Protection from infectious diseases due to immune system impairment | 1 or more | Medical Supports |
| 11 | Seizure management | 1 or more | Medical Supports |
| 12 | Dialysis | 1 or more | Medical Supports |
| 13 | Ostomy care | 1 or more | Medical Supports |
| 14 | Lifting and/or transferring | 1 or more | Medical Supports |
| 15 | Therapy services | 1 or more | Medical Supports |
| 16 | Diabetes management | 1 or more | Medical Supports |
| 17 | Other(s) | 1 or more | Medical Supports |

(3) Behavioral supports from the SIS exceptional behavior support needs scale

| # | Questions in the Exceptional Behavior Support Needs Scale: | DDD must address in your ISP if you have an acuity score of: | Health and Welfare Category |
|---|---|--|-----------------------------|
| 1 | Prevention of assaults or injuries to others | 1 or more | Behavioral Supports |
| 2 | Prevention of property destruction (e.g., fire setting, breaking furniture) | 1 or more | Behavioral Supports |
| 3 | Prevention of stealing | 1 or more | Behavioral Supports |
| 4 | Prevention of self-injury | 1 or more | Behavioral Supports |
| 5 | Prevention of pica (ingestion of inedible substances) | 1 or more | Behavioral Supports |
| 6 | Prevention of suicide attempts | 1 or more | Behavioral Supports |
| 7 | Prevention of sexual aggression | 1 or more | Behavioral Supports |
| 8 | Prevention of nonaggressive but inappropriate behavior (e.g., exposes self in public, exhibitionism, inappropriate touching or gesturing) | 1 or more | Behavioral Supports |
| 9 | Prevention of tantrums or emotional outbursts | 1 or more | Behavioral Supports |

| # | Questions in the Exceptional Behavior Support Needs Scale: | DDD must address in your ISP if you have an acuity score of: | Health and Welfare Category |
|----|--|--|-----------------------------|
| 10 | Prevention of wandering | 1 or more | Behavioral Supports |
| 11 | Prevention of substance abuse | 1 or more | Behavioral Supports |
| 12 | Maintenance of mental health treatments | 1 or more | Behavioral Supports |
| 13 | Managing attention-seeking behavior | 1 or more | Behavioral Supports |
| 14 | Managing uncooperative behavior | 1 or more | Behavioral Supports |
| 15 | Managing agitated/over-reactive behavior | 1 or more | Behavioral Supports |
| 16 | Managing obsessive/repetitive behavior | 1 or more | Behavioral Supports |
| 17 | Prevention of other serious behavior problem(s) | 1 or more | Behavioral Supports |

(4) Caregiver from the SIS exceptional behavior support needs scale

| # | Question in the DDD Caregiver Status Acuity Scale: | DDD must address in your ISP if you have a score: | Health and Welfare Category |
|---|--|---|-----------------------------|
| 6 | How long do you think you expect to continue providing care? | 1 to 6 months or less than 1 month | DDD Caregiver Status |

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-8040, filed 4/23/07, effective 6/1/07.]

WAC 388-828-8060 How does DDD determine which health and welfare needs must be addressed in your individual support plan if you are age sixteen or older? (1) If you are age sixteen or older and receiving DDD HCBS waiver services or reside in a state-only residential setting, DDD uses the following table to determine the health and welfare needs that must be addressed in your individual support plan:

| # | SIS Activity | DDD must address in the ISP if your Type of Support score is: | Health and Welfare Category |
|----|--|---|-----------------------------|
| A1 | Using the toilet | 3 or more | Home Living |
| A2 | Taking care of clothes (includes laundering) | 3 or more | |
| A3 | Preparing food | 3 or more | |
| A4 | Eating food | 3 or more | |
| A5 | Housekeeping and cleaning | 3 or more | |
| A6 | Dressing | 3 or more | |
| A7 | Bathing and taking care of personal hygiene and grooming needs | 3 or more | |
| A8 | Operating home appliances | 3 or more | |
| A9 | Using currently prescribed equipment or treatment | 3 or more | |
| B1 | Getting from place to place throughout the community (transportation) | 2 or more | Community Living |
| B2 | Participating in recreation/leisure activities in the community settings | 2 or more | |
| B3 | Using public services in the community | 2 or more | |
| B4 | Going to visit friends and family | 4 | |
| B6 | Shopping and purchasing goods and services | 2 or more | |
| B7 | Interacting with community members | 4 | Employment |
| B8 | Accessing public buildings and settings | 2 or more | |
| D3 | Interacting with co-workers | 3 or more | |
| D4 | Interacting with supervisors and or coaches | 3 or more | Health and Safety |
| E1 | Taking medications | 2 or more | |
| E2 | Avoiding health and safety hazards | 3 or more | |
| E3 | Obtaining health care services | 3 or more | |
| E4 | Ambulating and moving about | 3 or more | |
| E6 | Maintaining a nutritious diet | 3 or more | Health and Safety |
| E7 | Maintaining physical health and fitness | 3 or more | |

| # | SIS Activity | DDD must address in the ISP if your Type of Support score is: | Health and Welfare Category |
|----|--|---|-----------------------------|
| F2 | Participating in recreation/leisure activities with others | 2 or more | Social Activities |
| F4 | Making and keeping friends | 4 | |
| F6 | Using appropriate social skills | 4 | |
| G2 | Managing money and personal finances | 2 or more | Protection and Advocacy |
| G3 | Protecting self from exploitation | 2 or more | |
| G7 | Making choices and decisions | 2 or more | |

(2) If you have a support score of one or more for any of the questions in the SIS exceptional medical support needs scale, DDD must address your support need using the medical supports category.

(3) If you have a support score of one or more for any of the questions in the SIS exceptional behavior support needs scale, DDD must address your support need using the behavior supports category.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-8060, filed 4/23/07, effective 6/1/07.]

**Chapter 388-829A WAC
ALTERNATIVE LIVING**

WAC

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- 388-829A-300 When must DDD deny the client's choice of an alternative living provider?
- 388-829A-310 What if the alternative living provider no longer wants to provide services to a client?
- 388-829A-320 What are the client's rights if DDD denies, or terminates an alternative living services contract?
- 388-829A-330 Does the provider of alternative living services have a right to an administrative hearing?

WAC 388-829A-005 What is the purpose of this chapter? This chapter establishes rules governing the division of developmental disabilities alternative living services program per chapter 71A.12 RCW for eligible clients of the division.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-005, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-010 What definitions apply to this chapter? The following definitions apply to this chapter:

"ADSA" means the aging and disability services administration within DSHS and its employees and authorized agents.

"Adult protective services" or "APS" means the investigative body designated by ADSA to investigate suspected cases of abandonment, abuse, financial exploitation and neglect as defined in 74.34 RCW.

"Alternative living provider" means an independent contractor with a current contract with the division of developmental disabilities to provide alternative living services.

"Assistance" means help provided to a client for the purpose of training the client in the performance of tasks the task being trained. Assistance does not include personal care as defined in chapter 388-106 WAC or protective supervision.

"Calendar year" means the twelve month period that runs from January 1 through December 31.

"Case manager" means the division of developmental disabilities case resource manager or social worker assigned to a client.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Competence" means the capacity to do what one needs and wants to do. There are two ways to be competent. A person may be self-reliant and able to do things for themselves or may have the power to identify and obtain the help needed from others.

"DDD" or "the division" means the division of developmental disabilities (DDD) within the DSHS aging and disabilities services administration of the department of social and health services.

"DDD specialty training" means department approved curriculum to provide information and instruction to meet the special needs of people with developmental disabilities.

"DSHS" or "the department" means the state of Washington department of social and health services and its employees and authorized agents.

"Health and safety" means clients living safely in environments common to other citizens with reasonable supports offered to simultaneously protect their health and safety while promoting community inclusion.

"Individual support plan" or "ISP" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Integration" means clients being present and actively participating in the community using the same resources and doing the same activities as other citizens.

"Mandatory reporter" means any person working with vulnerable adults required by law to report incidents of abandonment, abuse, neglect, financial exploitation, etc per chapter 74.34 RCW.

"Positive recognition by self and others" means a client being offered assistance in ways which promote the client's status and creditability. Providers offer assistance in ways that are appropriate to the age of the client, typical to other members of the community and contribute to the client's feelings of self worth and positive regard by others.

"Positive relationships" means clients having friends and family that offer essential support and protection. Friends and family lend continuity and meaning through life and open the way to new opportunities and experiences.

"Power and choice" means clients experiencing power, control, and ownership of their personal affairs. Expression of personal power and choice are essential elements in the lives of people. Such expressions help people gain autonomy, become self-governing and pursue their own interests and goals.

"Regulation" means any federal, state, or local law, rule, ordinance or policy.

"RCW" means the Revised Code of Washington, which contains all laws governing the state of Washington.

"Service episode record" or "SER" means documentation by DDD of all client related contacts including contacts during the assessment, service plan, coordination and monitoring of care and termination of services.

"Support" means provider activities done on the client's behalf such as balancing the checkbook.

"Unusual incidents" means a change in circumstances or events that concern a client's safety or well-being. Examples may include, an increased frequency, intensity, or duration of any medical conditions, adverse reactions to medication, hospitalization, death, severe behavioral incidents that are unlike the client's ordinary behavior, severe injury, running away, physical or verbal abuse to themselves or others, etc

"WAC" means the Washington Administrative Code, which are the rules for administering the state laws (RCW).

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-010, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-020 What are alternative living services? Alternative living services provide community-based,

individualized client training, assistance, and support. These services enable a client to live as independently as possible.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-020, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-030 What type of training and support may the alternative living service provider offer?

The alternative living service provider may provide training, assistance, and/or support in the following areas, as identified in the client's individual support plan (ISP):

- (1) Establishing a residence.
- (2) Home living including:
 - (a) Personal hygiene;
 - (b) Food and nutrition; and
 - (c) Home management.
- (3) Community living including:
 - (a) Accessing public and private community services;
 - (b) Essential shopping; and
 - (c) Transportation.
- (4) Health and safety including:
 - (a) Understanding personal safety and emergency procedures;
 - (b) Physical, mental and dental health; and
 - (c) Developing and practicing an emergency response plan to address natural and other disasters.
- (5) Social activities including:
 - (a) Community integration; and
 - (b) Building relationships.
- (6) Protection and advocacy including:
 - (a) Money management and budgeting;
 - (b) Protecting self from exploitation;
 - (c) Making choices and decisions; and
 - (d) Asserting rights and finding advocacy.
- (7) Other training and support to assist a client to live independently.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-030, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-040 Who is eligible to receive alternative living services? Clients who receive alternative living services must:

- (1) Be at least eighteen years of age;
- (2) Live outside of their parent's home or plan to move out of their parent's home in the next six months;
- (3) Have an assessed need for alternative living services;
- (4) Be authorized by DDD to receive alternative living services; and
- (5) Be able to afford and maintain their own home with their personal financial resources.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-040, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-050 Who is eligible to contract with DDD to provide alternative living services? Before DDD may issue an alternative living contract, the prospective provider must:

- (1) Be twenty-one years of age or older;
- (2) Have a high school diploma or GED;
- (3) Clear a background check conducted by DSHS, as required by RCW 43.20A.710;

(4) Have an FBI fingerprint-based background check as required by RCW 43.20A.710, if the person has not lived in the state continuously for the previous three years;

(5) Have a business ID number, as an independent contractor; and

(6) Meet the minimum skills and abilities described in WAC 388-829A-110.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-050, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-060 Who may not be contracted to provide alternative living services? DDD may not contract with the following to provide alternative living services:

(1) The client's spouse.

(2) The client's natural, stepparent or adoptive parents.

(3) The court appointed legal representative.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-060, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-070 Where must alternative living services be provided? (1) Alternative living services must be provided in a community setting.

(2) Clients receiving alternative living services must live independently in a home that is owned, rented or leased by the client or the client's legal representative.

(3) Alternative living services may be provided in the parent's home for no more than six months, to support a client's transition from the parent's home into the client's own home.

(4) Alternative living services may not be offered in the provider's home.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-070, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-080 How many hours of alternative living services may a client receive? Alternative living services may be authorized up to forty hours per month.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-080, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-090 May an alternative living provider claim reimbursement for more than one client at a time? An alternative living provider must not claim reimbursement for more than one client per service hour.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-090, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-100 May an alternative living provider offer personal care or respite services? An alternative living provider must not offer personal care or respite under their alternative living contract. The alternative living provider must have a separate contract to provide respite and/or personal care services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-100, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-110 What minimum skills and abilities must alternative living providers demonstrate? Alternative living providers must:

(1) Be able to read, understand, and provide services as outlined in the ISP;

(2) Participate in the development of the client's ISP;

(3) Communicate in a language of the client served;

(4) Accommodate the client's individual preferences;

(5) Know the community resources such as medical facilities, emergency resources, recreational opportunities;

(6) Protect the client's financial interests;

(7) Fulfill reporting requirements as required in this chapter and the alternative living contract;

(8) Know how and when to contact the client's representative and the client's case manager;

(9) Maintain all necessary license, and certification as required by law (see WAC 388-829A-140, 388-829A-160, and 388-829A-270);

(10) Successfully complete the training required in this chapter; and

(11) Comply with all applicable laws, regulations, policy, and contract requirements.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-110, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-120 What values must alternative living providers focus on when implementing the ISP? The alternative living provider must focus on the following values when implementing the ISP:

(1) Health and safety;

(2) Personal power and choice;

(3) Competence and self-reliance;

(4) Positive recognition by self and others;

(5) Positive relationships; and

(6) Integration in the physical and social life of the community.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-120, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-130 What rights do clients of DDD have? Clients of DDD have:

(1) The same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution and federal and state law;

(2) The right to be free from discrimination because of race, color, national origin, gender, age, religion, creed, marital status, disabled or veteran status, use of a trained service animal or the presence of any physical, mental or sensory handicap.

(3) The right to treatment and habilitation services to foster developmental potential and protect personal liberty in the least restrictive environment;

(4) The right to dignity, privacy, and humane care;

(5) The right to participate in an appropriate program of publicly supported education;

(6) The right to prompt medical care and treatment;

(7) The right to social interaction and participation in community activities;

(8) The right to physical exercise and recreational opportunities;

(9) The right to work and be paid for the work one does;

(10) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, or financial exploitation;

(11) The right to be free from hazardous or experimental procedures;

(12) The right to freedom of expression and to make decisions about one's life;

(13) The right to complain, disagree with, and appeal decisions made by the provider or DDD; and

(14) The right to be informed of these rights in a language that he or she understands.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-130, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-140 What training must be completed before becoming an alternative living provider? Before DDD may issue an alternative living contract, the prospective provider must:

- (1) Obtain CPR/first-aid certification;
- (2) Successfully complete bloodborne pathogens training with HIV/Aids information; and
- (3) Receive contract orientation and client specific training from DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-140, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-150 What training must an alternative living provider complete within the first ninety days of serving the client? The alternative living provider must successfully complete the approved DDD specialty training within the first ninety days of serving the client (see WAC 388-112-0120). (Note: DDD will reimburse the provider for training time for DDD specialty training only when the provider is currently offering alternative living services to a client.)

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-150, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-160 What training must an alternative living provider complete after the first year of service? (1) After the first year of service, the alternative living provider must:

- (a) Maintain current CPR/first-aid certification;
- (b) Receive bloodborne pathogens training with HIV/Aids information at least annually and within one year of the previous training; and
- (c) Complete at least ten hours of continuing education each calendar year after the calendar year in which they successfully complete DDD approved specialty training.
 - (i) The continuing education must be on topics relevant to supporting individuals with developmental disabilities.
 - (ii) One hour of completed classroom instruction or other form of training (such as a video or on-line course) equals one hour of continuing education.

(2) Documentation of training attendance must be kept in the provider's files and submitted to DDD upon completion of the training.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-160, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-170 What information must alternative living providers keep in their records? Alternative liv-

ing providers must keep the following information in their records:

- (1) Client information:
 - (a) The client's name, address, and telephone number;
 - (b) The name, address, and telephone number of the client's legal representative, health care provider and any of the client's relatives that the client chooses to include;
 - (c) A copy of the client's most recent ISP;
 - (d) Copies of any positive behavior support plan or cross systems crisis plan, if applicable; and
 - (e) A copy of the current plan for alternative living services.
- (2) Provider Information:
 - (a) Provider training records (see WAC 388-829A-140 through 388-829A-160);
 - (b) All written reports submitted to DDD (see WAC 388-829A-180);
 - (c) Copies of the department approved service verification records, as specified in the provider's alternative living contract;
 - (d) Signed DDD policy on residential reporting requirements as specified in the alternative living contract; and
 - (e) Payment records.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-170, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-180 What written reports must be submitted to DDD? The alternative living provider must submit the following written reports to DDD:

- (1) Reports on unusual incidents and emergencies as specified in the alternative living contract; and
- (2) Quarterly reports providing information about the type and extent of services performed as identified in the ISP.
 - (a) The information in the reports must reflect the reporting period.
 - (b) These reports must be submitted at least quarterly or more often as required by the ISP and alternative living plan; and
 - (3) Service verification records at least quarterly or more often if required by DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-180, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-190 What are the requirements for entries in the client record maintained by the alternative living provider? (1) When making entries to the client record, the alternative living provider must:

- (a) Note all record entries in ink or electronically;
 - (b) Make entries at the time of or immediately following the occurrence of the event recorded;
 - (c) Make entries in legible writing; and
 - (d) Sign and date entries in ink.
- (2) If a provider makes a mistake on the record, they must keep both the original and corrected entries.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-190, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-200 How long must an alternative living provider keep client records? An alternative living provider must keep a client's records for a period of six years.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-200, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-210 Are clients' records considered confidential? Alternative living providers must consider all client record information privileged and confidential.

(1) Any transfer or inspection of records, to anyone but DDD, must be authorized by a release of information form that:

(a) Specifically gives information about the transfer or inspection; and

(b) Is signed by the client or legal representative.

(2) A signed release of information is valid for up to one year and must be renewed annually from the signature date.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-210, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-220 Are alternative living providers mandatory reporters? (1) Alternative living providers are mandatory reporters. They must report instances of suspected abandonment, abuse, neglect, or financial exploitation of vulnerable adults as defined in chapter 74.34 RCW.

(2) Each alternative living provider must comply with DDD residential reporting requirements as specified in their alternative living contract.

(3) Providers must retain a signed copy of the DDD policy on residential reporting requirements specified in the alternative living contract and submit a signed copy of the policy to DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-220, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-230 How must alternative living providers report abuse and neglect? Alternative living providers must immediately report suspected abandonment, abuse, neglect or financial exploitation of vulnerable adults to:

(1) Adult protective services using the DSHS toll free telephone number, provided by the department. 1-866-END-HARM or 1-866-363-4276.

(2) DDD in compliance with the DDD residential reporting requirements specified in their alternative living contract; and

(3) Law enforcement agencies, as required under chapter 74.34 RCW, including when there is reason to suspect sexual or physical abuse.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-230, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-240 What must alternative living providers do in an emergency? In an emergency, the alternative living provider must:

(1) Immediately call 911, in a life threatening emergency;

(2) Provide emergency services, then notify:

(a) The client's legal representative; and

(b) The division of developmental disabilities.

(3) Submit a written report to DDD, as required by DDD residential reporting requirements specified in the alternative living contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-240, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-250 What is an individual support plan (ISP)? (1) The individual support plan (ISP) is the primary tool DDD uses to:

(a) Determine and document the client's needs; and

(b) Identify the services to meet those needs.

(2) The existing plan of care (POC) for the client remains in effect until a new ISP is developed.

(3) The ISP must include (see chapter 388-828 WAC):

(a) The client's identified health and welfare needs;

(b) Both paid and unpaid services approved to meet the identified health and welfare needs;

(c) How often the client will receive each service;

(d) How long the client will need each service; and

(e) Who will provide each service.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-250, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-260 Are alternative living providers responsible to transport a client? Alternative living providers may provide transportation if specified in the client's ISP.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-260, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-270 What requirements must be met before an alternative living provider transports a client? Before transporting a client, alternative living providers must:

(1) Carry auto insurance as required by chapters 46.29 and 46.30 RCW; and

(2) Have a valid driver's license as required by chapter 46.20 RCW.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-270, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-280 How will DDD monitor alternative living services? (1) DDD must use the following monitoring process to oversee alternative living services and providers:

(a) Conduct an in-home visit every twelve months;

(b) Review all written reports from the provider for compliance with the instruction and support goals specified in the client's ISP; and

(c) Initial and file all written reports submitted by the provider and document in the service episode record.

(2) DDD must conduct an annual evaluation of the alternative living program with a sample of alternative living providers and clients who receive services. If the evaluation indicates concerns, a corrective action plan will be developed. The corrective action plan will:

(a) Outline methods for the provider to comply with the requirements; and

(b) Provide a time frame for completion of the corrective actions.

(3) DDD may stop the authorization for payment or terminate the contract if the corrective actions are not completed with the specified timeline.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-280, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-290 When may DDD not authorize payment or terminate a contract for alternative living services? DDD may not authorize payment or may terminate a contract for the services of an alternative living provider, when that provider:

- (1) Is no longer the client's choice of provider.
- (2) Demonstrates inadequate performance or inability to deliver quality care which is jeopardizing the client's health, safety, or well-being. DDD may terminate the contract based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy.
- (3) Is unable to clear a background check required by RCW 43.20A.710.
- (4) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830.
- (5) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW.
- (6) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations.
- (7) Does not successfully complete the training requirements within the time limits required in this chapter.
- (8) Does not complete the corrective action within the agreed upon time frame.
- (9) Fails to comply with the requirements of this chapter, or the DDD alternative living contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-290, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-300 When must DDD deny the client's choice of an alternative living provider? DDD must deny a client's request to have a certain provider and must not enter into a contract with the person when any of the following exist:

- (1) The person is the client's spouse, under 42 CFR 441.360(g).
- (2) The person is the client's natural/step/adoptive parent.
- (3) The person is the client's court-appointed legal representative.
- (4) DDD has a reasonable, good faith belief that the provider will be unable to meet the client's needs. Examples of a provider's inability to meet the client's needs may include:
 - (a) Evidence of alcohol or drug abuse;
 - (b) A reported history of domestic violence, no-contact orders, or criminal conduct (whether or not the conduct is disqualifying under RCW 43.43.830 and 43.43.842);
 - (c) A report from the client's health care provider or another knowledgeable person that the requested provider lacks the ability or willingness to provide adequate support;
 - (d) Other employment or responsibilities that prevent or interfere with the provision of required services;
 - (e) A reported history of mismanagement of client funds or DSHS contract violations; or
 - (f) Excessive commuting distance that would make it impractical to provide services as they are needed and outlined in the client's ISP.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-300, filed 7/31/07, effective 9/1/07.]

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WAC 388-829A-310 What if the alternative living provider no longer wants to provide services to a client? When an alternative living provider no longer wants to provide services to a client, the provider must:

- (1) Give at least two weeks notice to:
 - (a) The client;
 - (b) The client's legal representative; and
 - (c) DDD.
- (2) If an emergency occurs and services must be terminated immediately, the provider must give immediate notice to DDD, the client and the client's representative.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-310, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-320 What are the client's rights if DDD denies, or terminates an alternative living services contract? If DDD denies, or terminates an alternative living services contract, the client has the right to an administrative hearing to appeal the decision, per chapter 388-02 WAC and WAC 388-825-120.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-320, filed 7/31/07, effective 9/1/07.]

WAC 388-829A-330 Does the provider of alternative living services have a right to an administrative hearing? The alternative living provider does not have a right to an administrative hearing.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-101, § 388-829A-330, filed 7/31/07, effective 9/1/07.]

Chapter 388-829C WAC COMPANION HOMES

WAC

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WAC 388-829C-005 What is the purpose of this chapter? This chapter establishes rules governing the division of developmental disabilities (DDD) companion home residential services program per chapter 71A.12 RCW for eligible clients of the division.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-005, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-010 What definitions apply to this chapter? The following definitions apply to this chapter:

"ADSA" means the aging and disability services administration within DSHS and its employees and authorized agents.

"Adult protective services" or "APS" means the investigative body designated by ADSA to investigate suspected cases of abandonment, abuse, financial exploitation and neglect as defined in 74.34 RCW.

"Calendar year" means the twelve month period that runs from January 1 through December 31.

"Case manager" means the DDD case resource manager or social worker assigned to a client.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Competence" means the capacity to do what one needs and wants to do. There are two ways to be competent. A person may be self-reliant and able to do things for themselves or may have the power to identify and obtain the help needed from others.

"DDD" or "the division" means the division of developmental disabilities, a division within the DSHS aging and disabilities services administration, of the department of social and health services.

"DDD specialty training" means department approved curriculum to provide information and instruction to meet the special needs of people with developmental disabilities.

"DSHS" or "the department" means the state of Washington department of social and health services and its employees and authorized agents.

"Health and safety" means clients should live safely in environments common to other citizens with reasonable supports offered to simultaneously protect their health and safety while promoting community inclusion

"Individual support plan" or "ISP" is a document that authorizes and identifies the DDD paid services that meet a client's assessed needs.

"Integration" means clients being present and actively participating in the community using the same resources and doing the same activities as other citizens.

"Mandatory reporter" means any person working with vulnerable adults required by law to report incidents of abandonment, abuse, neglect, financial exploitation, etc., per chapter 74.34 RCW.

"NA-R" means nursing assistant-registered under chapter 18.88A RCW.

"NA-C" means nursing assistant-certified under chapter 18.88A RCW.

"Positive recognition by self and others" means a client being offered assistance in ways which promote the client's status and creditability. Providers offer assistance in ways that are appropriate to the age of the client, typical to other members of the community and contribute to the client's feelings of self worth and positive regard by others.

"Positive relationships" means clients having friends and family that offer essential support and protection. Friends and family lend continuity and meaning through life and open the way to new opportunities and experiences.

"Power and choice" means clients experiencing power, control and ownership of personal affairs. Expression of personal power and choice are essential elements in the lives of people. Such expressions help people gain autonomy, become self-governing and pursue their own interests and goals.

"Registered nurse delegation" means the process by which a registered nurse transfers the performance of selected nursing tasks to a registered or certified nursing assistant in selected situations. (For detailed information, please refer to chapter 18.79 RCW and WAC 388-840-910 through 388-840-970.)

"Regulation" means any federal, state, or local law, rule, ordinance or policy.

"Respite" means care that is intended to provide short-term intermittent relief for persons providing care for companion home clients.

"RCW" means the Revised Code of Washington, which contains all laws governing the state of Washington.

"Service episode record" or "SER" means documentation by DDD of all client related contacts including contacts during the assessment, service plan, coordination and monitoring of care and termination of services.

"Unusual incidents" means a change in circumstances or events that concern a client's safety or well-being. Examples include, an increased frequency, intensity, or duration of any medical conditions, adverse reactions to medication, hospitalization, death, severe behavioral incidents, severe injury, running away, physical or verbal abuse to themselves or others.

"WAC" means the Washington Administrative Code, which contains the rules for administering the state laws (RCW).

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-010, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-020 What are companion home residential services? (1) A companion home is a DDD residential service offered in the provider's home to no more than one client.

(2) Companion home residential services provide twenty-four hour instruction and support services.

(3) Companion home residential services are based on the client's ISP.

(4) Companion home residential services are provided by an independent contractor.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-020, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-030 Who may receive companion home residential services? Clients who may receive companion home residential services must:

(1) Be at least eighteen years old;

(2) Have an assessed need for companion home services; and

(3) Meet one of the following conditions:

(a) Be authorized by DDD to receive companion home residential services, as outlined in this chapter; or

(b) Have a written agreement with the provider to purchase companion home residential services using the client's own personal financial resources.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-030, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-040 Who is eligible to contract with DDD to provide companion home residential services? To be eligible to contract with DDD to provide companion home residential services, a person must:

(1) Be twenty-one years of age or older;

(2) Have a high school diploma or GED;

(3) Clear a background check conducted by DSHS as required by RCW 43.20A.710;

(4) Have an FBI fingerprint-based background check as required by RCW 43.20A.710, if the person has not lived in the state continuously for the previous three years;

(5) Have a business ID number, as an independent contractor; and

(6) Meet the minimum skills and abilities described in WAC 388-829C-080.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-040, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-050 Who may not provide companion home residential services? DDD may not contract with any of the following to provide companion home residential services:

(1) The client's spouse.

(2) The client's natural, step, or adoptive parents.

(3) The client's court-appointed legal representative.

(4) Any person providing department paid services to any other DSHS client.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-050, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-060 Where are companion home residential services provided? (1) Companion home residential services are offered to clients living in the provider's home.

(2) The provider's home must be approved by DDD, to assure client health, safety, and well-being consistent with the requirements in this chapter.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-060, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-070 Who must have a background check in the companion home? (1) All individuals living in the household, except the client, must have a current DSHS background check if they:

(a) Are at least sixteen years old; and

(b) Reside in the companion home.

(2) Household residents who have not lived in Washington continuously for the previous three years must also have an FBI fingerprint-based background check as required by RCW 43.20A.710.

(3) Background checks must be completed every two years or more frequently when requested by the department.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-070, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-080 What minimum skills and abilities must companion home providers demonstrate? Companion home providers must:

(1) Be able to read, understand, and provide services outlined in the ISP;

(2) Participate in the development of the ISP;

(3) Communicate in the language of the client served;

(4) Accommodate the client's individual preferences;

(5) Know the community resources, such as: Medical facilities, emergency resources, and recreational opportunities;

(6) Enable the client to keep in touch with family and friends in a way preferred by the client;

- (7) Protect the client's financial interests;
- (8) Fulfill reporting requirements as required in this chapter and the companion home contract;
- (9) Know how and when to contact the client's representative and the client's case manager;
- (10) Successfully complete the training required in this chapter;
- (11) Maintain all necessary license, registration and certification required under this chapter, (see WAC 388-829C-110, 388-829C-130, 388-829C-190, and 388-829C-260); and
- (12) Comply with all applicable laws, regulations and contract requirements.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-080, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-090 What values must companion home providers focus on when implementing the ISP?

The companion home provider must focus on the following values when implementing the individual support plan (ISP):

- (1) Health and safety;
- (2) Personal power and choice;
- (3) Competence and self-reliance;
- (4) Positive recognition by self and others;
- (5) Positive relationships; and
- (6) Integration in the physical and social life of the community.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-090, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-100 What rights do clients of DDD have? Clients of DDD have:

- (1) The same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution and federal and state law;
- (2) The right to be free from discrimination because of race, color, national origin, gender, age, religion, creed, marital status, disabled or veteran status, use of a trained service animal or the presence of any physical, mental or sensory handicap;
- (3) The right to treatment and habilitation services to foster developmental potential and protect personal liberty in the least restrictive environment;
- (4) The right to dignity, privacy, and humane care;
- (5) The right to participate in an appropriate program of publicly supported education;
- (6) The right to prompt medical care and treatment;
- (7) The right to social interaction and participation in community activities;
- (8) The right to physical exercise and recreational opportunities;
- (9) The right to work and be paid for the work one does;
- (10) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, or financial exploitation;
- (11) The right to be free from hazardous or experimental procedures;
- (12) The right to freedom of expression and to make decisions about one's life;
- (13) The right to complain, disagree with, and appeal decisions made by the provider or DDD; and

- (14) The right to be informed of these rights in a language that he or she understands.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-100, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-110 What training must a person have before becoming a contracted companion home provider? Before DDD may issue a companion home contract, the prospective provider must:

- (1) Obtain CPR and first aid certification;
- (2) Successfully complete bloodborne pathogens training with HIV/AIDS information; and
- (3) Receive contract orientation and client specific training from DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-110, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-120 What training must a companion home provider complete within the first ninety days of serving the client? The companion home provider must successfully complete the DDD specialty training within the first ninety days of serving the client. (See WAC 388-112-0120.)

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-120, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-130 What training must a companion home provider complete after the first year of service?

After the first year of service, the companion home provider must:

- (1) Maintain current CPR and first-aid certification;
- (2) Receive bloodborne pathogens training with HIV/AIDS information at least annually and within one year of the previous training; and
- (3) Complete at least ten hours of continuing education each calendar year after the calendar year in which they successfully complete DDD approved specialty training.
 - (a) The continuing education must be on topics that will directly benefit the client being served.
 - (b) One hour of completed classroom instruction or other form of training (such as a video or on-line course) equals one hour of continuing education.
- (4) Documentation of training attendance must be kept in the provider's files and submitted to DDD upon completion of the training.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-130, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-140 Are companion home providers mandatory reporters?

(1) Companion home providers are mandatory reporters. They must report all instances of suspected abandonment, abuse, financial exploitation or neglect of vulnerable adults as defined in chapter 74.34 RCW.

(2) Companion home providers must comply with DDD's residential reporting requirements specified in the companion home contract.

(3) Providers must retain a signed copy of the DDD policy on residential reporting requirements specified in the companion home contract and submit a signed copy of the policy to DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-140, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-150 How must companion home providers report abuse and neglect? Companion home providers must immediately report suspected abandonment, abuse, financial exploitation or neglect of vulnerable adults to:

- (1) Adult protective services using the DSHS toll free telephone number, provided by the department. 1-866-END-HARM or 1-866-363-4276;
- (2) DDD in compliance with the DDD residential reporting requirements as specified in the companion home contract; and
- (3) Law enforcement agencies, as required under chapter 74.34 RCW, including when there is reason to suspect sexual or physical abuse.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-150, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-160 What health care assistance must a companion home provide a client? The companion home provider must provide the client necessary health care assistance by:

- (1) Arranging appointments and accessing health, mental health, and dental services;
- (2) Ensuring the client receives an annual physical and dental examination, unless the physician or dentist gives a written exemption. For client refusal of services, see WAC 388-829C-310;
- (3) Observing the client for changes(s) in health, taking appropriate action and responding to emergencies;
- (4) Managing medication assistance per chapter 246-888 WAC and administration per WAC 246-840-910 to 246-840-970 and per the DDD residential medication management requirements specified in the companion home contract;
- (5) Maintaining health records (see WAC 388-829C-280);
- (6) Assisting client with any medical treatment prescribed by health professionals that does not require registered nurse delegation or professionally licensed services;
- (7) Communicating directly with health professionals when needed; and
- (8) Providing a balanced, nutritional diet.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-160, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-170 How may a companion home provider assist a client with medications? (1) A companion home provider may provide medication assistance per chapter 246-888 WAC, if the client:

- (a) Is able to put the medication into his or her mouth or apply or instill the medication; and
 - (b) Is aware that they are receiving medication.
- (2) Some tasks that may be provided under the Medication assistance, chapter 246-888 WAC, are listed in the following chart. Medication assistance may only be provided if the client meets both criteria in (a) and (b) of this section.

| | |
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| | May a companion home provider complete this task if the client meets both criteria in (a) and (b) of this section? |
| Medication Assistance Task | |
| Remind or coach the client to take their medication. | Yes |
| Open the medication container. | Yes |
| Hand client the medication container. | Yes |
| Place medication in the client's hand; | Yes |
| Transfer medication from a container to another for the purpose of an individual dose (e.g., pouring liquid medication from a container to a calibrated spoon, medication cup or adaptive device). | Yes |
| Alter a medication by crushing, mixing, etc. | Yes, if the client is aware that the medication is being altered or added to food or beverage. A pharmacist or other qualified practitioner must determine it is safe to alter a medication and this must be documented on the prescription container or in the client's record. |
| Handing the client a pre-filled insulin syringe. | Yes, but the client must be able to inject the insulin by him or herself. |
| Guide or assist client to apply or instill skin, nose, eye and ear preparations. | Yes, but hand-over-hand administration is not allowed. |
| Assistance with injectable or IV medications. | No, this is not allowed. |
| Hand-over-hand assistance with medication. | No, may only be done under registered nurse delegation. |
| Assistance with medication beyond the examples provided above. | No, may only be done under registered nurse delegation. |

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-170, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-180 What is required for a companion home provider to administer medications and provide delegated nursing tasks? Companion home providers must meet the following requirements before administering medications and providing nursing tasks for their clients. The companion home provider must either:

- (1) Be a registered nurse (RN) or licensed practical nurse (LPN); or
- (2) Be delegated to perform nursing care tasks by a registered nurse as described in WAC 388-829C-190.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-180, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-190 What is required for a companion home provider to perform nursing tasks under the registered nurse delegation program? In order to be delegated to perform nursing tasks, a companion home provider must:

(1) Verify with the delegating registered nurse that they have complied with chapters 18.79 and 18.88 RCW and WAC 246-840-910 through 246-840-990 by presenting:

(a) A current NA-R or NA-C registration without restriction;

(b) Certification showing completion of the "nurse delegation for nursing assistants" class; and

(c) Certification showing completion of "fundamentals of caregiving" if the companion home provider is an NA-R.

(2) Receive client-specific training from the delegating registered nurse; and

(3) Renew nursing assistant registration/certification annually.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-190, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-200 When must a companion home provider become delegated to perform nursing tasks? (1)

If a client needs registered nurse delegation, the companion home provider must comply with the requirements necessary to perform delegated nursing tasks before offering services to the client. (Note: A companion home provider may not offer support to a client whose needs they are unable to meet.)

(2) If the companion home provider is not eligible to perform nursing tasks, the task must be provided by a person legally authorized to do so such as an RN or LPN.

(3) The companion home provider must become eligible to perform nursing tasks within thirty days of the client being assessed to need medication administration.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-200, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-210 What records must the companion home provider keep regarding registered nurse delegation? (1)

The companion home provider must keep the following records when participating in registered nurse delegation:

(a) Written instructions for performing the delegated task from the delegating RN;

(b) The most recent six months of documentation showing that the task was performed; and

(c) Validation of their current nursing assistant registration or certification.

(2) These records must be kept in the companion home and be accessible to the delegating nurse at all times.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-210, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-220 What is an individual support plan (ISP)? (1) The individual support plan (ISP) is the primary tool DDD uses to:

(a) Determine and document the client's needs; and

(b) Identify the services to meet those needs.

(2) The existing plan of care (POC) for the client remains in effect until a new ISP is developed.

(3) The ISP must include (see chapter 388-828 WAC):

(a) The client's identified health and welfare needs;

(b) Both paid and unpaid services approved to meet the identified health and welfare needs;

(c) How often the client will receive each service;

(d) How long the client will need each service; and

(e) Who will provide each service.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-220, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-230 Are companion home clients eligible to receive respite? Companion home clients are eligible to receive respite care to provide intermittent relief to the companion home provider. The level of respite available to the companion home must be identified in the companion home contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-230, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-240 Where may respite care be provided? Respite care may be provided in the following location(s):

(1) The companion home where the client resides;

(2) Other places as designated in WAC 388-845-1610.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-240, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-250 Are companion home providers responsible to transport a client? The companion home provider must ensure that all of the client's transportation needs are met, as identified in the client's ISP.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-250, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-260 What requirements must be met before a companion home provider transports a client? Before transporting a client, companion home providers must:

(1) Carry automobile insurance per chapters 46.29 and 46.30 RCW; and

(2) Have a valid driver's license per chapter 46.20 RCW.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-260, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-270 May a companion home provider manage a client's funds? A companion home provider may manage, disperse, and limit access to a client's funds if:

(1) There is written consent from the client, when the client has no court appointed legal representative; or

(2) There is written consent from the client's court appointed legal representative for making financial decisions for the client; or

(3) The companion home provider is the designated payee for the client's earned and unearned income.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-270, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-280 What are the companion home provider's responsibilities when managing client funds? When managing the client's funds, the companion home provider must:

- (1) Keep the client's accounts current by maintaining a running balance;
- (2) Reconcile the client's accounts, including cash accounts, on a monthly basis;
- (3) Prevent the client's account from becoming overdrawn;
- (4) Keep receipts for purchases over twenty-five dollars;
- (5) Assist the client with any checks, if applicable;
- (6) Protect the client's financial interests; and
- (7) Ensure that the client is informed regarding how his or her money is being spent and that the client participates to the maximum extent possible in the decision making regarding his or her funds, consistent with responsible management of funds.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-280, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-290 What happens if a companion home provider mismanages a client's funds? (1) The companion home provider must reimburse the client, when responsible for mismanagement of client funds. The reimbursement includes any fees incurred as a result of the mismanagement, such as fees due to late payments.

(2) DDD may terminate the companion home contract if the provider has mismanaged client funds.

(3) Suspected exploitation of client finances must be reported to law enforcement and adult protective services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-290, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-300 What documents must companion home providers keep to protect a client's financial interests? To protect the client's financial interests, companion home providers must keep documents for the funds they manage for clients.

(1) All accounts must include the following documents:

- (a) Monthly bank statements and reconciliations initialed by the provider;
- (b) Checkbook registers and bankbooks;
- (c) Deposit receipts; and
- (d) Receipts for purchases over twenty-five dollars.

(2) If the companion home provider manages the client's funds or is the payee, they must notify DDD when they are aware that the client's funds reach one thousand seven hundred dollars.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-300, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-310 Must clients pay for room and board in the companion home? (1) Clients who receive companion home residential services must pay monthly room and board directly to the companion home provider from their personal financial resources.

(2) The monthly room and board the client pays to the provider is specified in a room and board agreement and includes rent, utilities, and food.

(3) The room and board agreement must be:

- (a) Developed by the client and the provider before the client moves into the companion home;

(b) Signed by the client, the client's legal representative and the provider; and

(c) Submitted to DDD for approval.

(4) Changes to the room and board agreement must be submitted to DDD for approval.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-310, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-320 What physical and safety requirements exist for companion homes? (1) Companion home providers must ensure that the following physical and safety requirements are met for the client:

(a) A safe and healthy environment;

(b) A separate bedroom;

(c) Accessible telephone equipment with local 911 access;

(d) A list of emergency contact numbers accessible to the client;

(e) An evacuation plan developed, posted, and practiced monthly with the client;

(f) An entrance and/or exit that does not rely solely upon windows, ladders, folding stairs, or trap doors;

(g) A safe storage area for flammable and combustible materials;

(h) Unblocked exits;

(i) Working smoke detectors which are located close to the client's room and meet the specific needs of the client;

(j) A flashlight or other non electrical light source in working condition;

(k) Fire extinguisher meeting the fire department standards; and

(l) Basic first-aid supplies.

(2) The companion home must be accessible to meet the client's needs.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-320, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-330 How must companion home providers regulate the water temperature at their residence? Companion home providers must regulate the water temperature at their residence.

(1) The water temperature in the household must be kept between 105 degrees and 120 degrees Fahrenheit.

(2) The provider must check the water temperature when the client first moves into the household and at least every six months from then on. (Note: The water temperature is best measured two hours after substantial hot water usage.)

(3) The companion home provider must document compliance with this requirement.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-330, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-340 What information must companion home providers keep in their records? Companion home providers must keep the following information in their records:

(1) Client information:

- (a) The client's name, address, and Social Security number;

(b) The name, address, and telephone number of the client's legal representative and any of the client's relatives that the client chooses to include;

(c) Client health records, including:

(i) The name, address, and telephone number of the client's physician, dentist, mental health service provider, and any other health care service provider;

(ii) Instructions from health care service providers about necessary health care, including appointment dates;

(iii) Written documentation that the instructions from health care service providers have been followed;

(iv) Medication, health, and surgery records; and

(v) A record of known surgeries and major health events;

(d) Copies of legal guardianship papers;

(e) A copy of the client's most recent ISP;

(f) Copies of any positive behavior support plan or cross systems crisis plan, if applicable;

(g) Financial records, if managing client funds (see WAC 388-829C-300);

(h) Client property records (see WAC 388-829C-380);

(i) Signed release of information forms; and

(j) Burial plans and wills.

(2) Provider information:

(a) Water temperature monitoring records (see WAC 388-829C-330);

(b) Provider training records (see WAC 388-829C-110 through 388-829C-130);

(c) Evacuation plan and practice records;

(d) Emergency response plan (see WAC 388-829C-410);

(e) All written reports submitted to DDD (see WAC 388-829C-350);

(f) Signed DDD policy on residential reporting requirements (see WAC 388-829C-140);

(g) Nurse delegation records (see WAC 388-829C-210); and

(h) Payment records.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-340, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-350 What written reports must be submitted to DDD? The companion home provider must submit the following written reports to DDD:

(a) Reports that describe the instruction and support activities performed as identified in the ISP. These reports must be submitted every six months or more frequently upon request of DDD.

(b) Reports on unusual incidents and emergencies as required in the DDD residential reporting requirements specified in the companion home contract.

(c) Reports on client refusal of services as described in this chapter (WAC 388-829C-370).

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-350, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-360 What are the requirements for record entries? (1) The companion home provider must

(a) Note all record entries in ink or electronically;

(b) Make entries at the time of or immediately following the occurrence of the event recorded;

(c) Make entries in legible writing; and

(d) Initial and date entries in ink.

(2) If a provider makes a mistake on the record, the provider must show both the original and corrected entries.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-360, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-370 Must a companion home provider document a client's refusal to participate in services? (1) A companion home provider must document a client's refusal to participate in:

(a) Physical and safety requirements as outlined in WAC 388-829C-320; and

(b) Health services as outlined in WAC 388-829C-160.

(2) When a client refuses to participate in these services, companion home providers must:

(a) Record a description of events relating to the client's refusal to participate in these services;

(b) Inform the client of the benefits of these services; and

(c) Provide the client or the client's legal representative and DDD with:

(i) A description of the service provider's efforts to give the services to the client; and

(ii) Any health or safety concerns that the refusal may pose.

(3) Companion home providers must submit this information to DDD in a written report as soon as possible following the client's refusal.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-370, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-380 Must companion home providers keep client's property records? The companion home provider must assist clients in maintaining current, written property records. The record must include:

(1) A list of items including a description, and serial numbers of items that are valued at seventy-five dollars or over; and were owned by the client when moving into the program.

(2) A list of items including a description, date of purchase and cost of items that are valued at seventy-five dollars or over and have been acquired by the client while living with the companion home provider.

(3) The record must contain dates and reasons for all items removed from the client's property record.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-380, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-390 Are clients' records considered confidential? The companion home provider must consider all client record information privileged and confidential.

(1) Any transfer or inspection of records, to parties other than DSHS, must be authorized by a release of information form that:

(a) Specifically gives information about the transfer or inspection; and

(b) Is signed by the client or the client's legal representative.

(2) A signed release of information is valid for up to one year and must be renewed annually from the signature date.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-390, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-400 How long must a companion home provider keep client records? A companion home provider must keep a client's records for a period of six years.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-400, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-410 What must companion home providers do when emergencies occur? (1) The companion home provider must develop an emergency response plan to address natural and other disasters and practice it with the client.

(2) In an emergency, the companion home provider must:

(a) Immediately call 911, in a life threatening emergency;

(b) Provide emergency services, then notify:

(i) The client's legal representative; and

(ii) The division of developmental disabilities.

(c) Submit a written report to DDD, as required by the DDD residential reporting requirements specified in the companion home contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-410, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-420 How must DDD monitor and provide oversight for companion home services? DDD must provide oversight and monitoring of the companion home provider through an annual review and evaluation, to ensure that the client's needs are being met. The evaluation will be conducted in the home where the client and provider live.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-420, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-430 How often must the companion home be evaluated? (1) An initial evaluation must be completed with the first ninety days after the companion home provider begins serving the client.

(2) Following the initial evaluation, the companion home provider must be evaluated at least every twelve months.

(3) DDD may conduct additional reviews at its discretion.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-430, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-440 How must the companion home provider participate in the evaluation process? The companion home provider must participate in the evaluation process by:

(1) Allowing scheduled and unscheduled home visits by DDD staff and the DDD contracted evaluators;

(2) Providing information and documentation as requested by the DDD and the DDD contracted evaluators; and

(3) Cooperating in setting up appointments with DDD and the DDD contracted evaluators.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-440, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-445 What occurs during the review and evaluation process? During the review and evaluation

process, DDD contracted evaluators will review compliance with this chapter, and the DDD companion home contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-445, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-450 What happens if the companion home provider is found to be out of compliance? If an evaluation finds the companion home provider out of compliance with any part of this chapter or the DDD contract, the provider and DDD must develop a corrective action plan.

(1) The corrective action plan must:

(a) Outline methods for the provider to comply with the required corrections; and

(b) Provide a time frame for the provider to complete the corrective actions.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-450, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-460 When may DDD stop the authorization for payment or terminate a contract for companion home services? DDD may stop the authorization for payment or terminate a contract for the services of a companion home provider, when that provider:

(1) Is no longer the client's choice of provider.

(2) Demonstrates inadequate performance or inability to deliver quality care which is jeopardizing the client's health, safety, or well-being. DDD may terminate the contract based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy.

(3) Is unable to clear a background check or other individuals living in the companion home are unable to clear a background check required by RCW 43.20A.710.

(4) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830.

(5) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW.

(6) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations.

(7) Does not successfully complete the training requirements within the time limits required in this chapter.

(8) Does not complete the corrective actions within the agreed upon time frame.

(9) Fails to comply with the requirements of this chapter or the companion home contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-460, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-470 When may DDD deny the client's choice of a companion home provider? DDD must deny a client's request to have a certain provider and must not enter into a contract with the person when any of the following exist:

(1) The person is the client's spouse, under 42 C.F.R. 441.360(g).

(2) The person is the client's natural/step/adoptive parent.

(3) The person is the client's court-appointed legal representative, unless the provider was contracted and paid to provide companion home services before February 2005.

(4) DDD has a reasonable, good faith belief that the provider will be unable to meet the client's needs. Examples of a provider's inability to meet the client's needs may include:

- (a) Evidence of alcohol or drug abuse;
- (b) A reported history of domestic violence, no-contact orders, or criminal conduct (whether or not the conduct is disqualifying under RCW 43.43.830 and 43.43.842);
- (c) A report from the client's health care provider or another knowledgeable person that the requested provider lacks the ability or willingness to provide adequate support;
- (d) Other employment or responsibilities that prevent or interfere with the provision of required services; or
- (e) A reported history of mismanagement of client funds or DSHS contract violations.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-470, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-480 What if the companion home provider no longer wants to provide services to a client?

(1) When a companion home provider no longer wants to provide services to a client, they must:

- (a) Give at least thirty days written notice to:
 - (i) The client;
 - (ii) The client's legal representative; and
 - (iii) DDD.
- (2) If an emergency occurs and services must be terminated immediately, the provider must give immediate notice to DDD, the client, and the client's representative.

(3) The companion home provider will be expected to continue working for thirty days unless otherwise determined by DDD.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-480, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-490 What are the client's appeal rights if DDD denies, or terminates a companion home services contract? If DDD denies, or terminates a companion home services contract, the client has the right to an administrative hearing to appeal the decision, per chapter 388-02 WAC and WAC 388-825-120.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-490, filed 7/31/07, effective 9/1/07.]

WAC 388-829C-500 Does the provider of companion home services have a right to an administrative hearing? The provider of companion home services does not have a right to an administrative hearing.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-500, filed 7/31/07, effective 9/1/07.]

Chapter 388-845 WAC

DDD HOME AND COMMUNITY BASED SERVICES WAIVERS

WAC

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DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

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| 388-845-0025 | Does this change in waivers affect the waiver services I am currently receiving? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0025, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-0075 | How is a child age twelve or younger assessed for ICF/MR level of care? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0075, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | 388-845-3035 |
| 388-845-0080 | What score indicates ICF/MR level of care if I am age twelve or younger? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0080, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | 388-845-3040 |
| 388-845-0085 | If I am age twelve or younger, what if my score on the current needs assessment does not indicate ICF/MR level of care? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0085, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | 388-845-3045 |
| 388-845-0090 | How is a person age thirteen or older assessed for ICF/MR level of care? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0090, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | 388-845-3050 |
| 388-845-0095 | What score indicates ICF/MR level of care if I am age thirteen or older? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0095, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-0096 | If I am age thirteen or older, what if my score on the current needs assessment does not indicate the need for ICF/MR level of care? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0096, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-1606 | Can DDD approve an exception to the requirements in WAC 388-845-1605? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1606, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-3005 | What is the waiver respite assessment? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3005, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-3010 | Who must have a waiver respite assessment? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3010, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-3025 | How often is this waiver respite assessment completed? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3025, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. | |
| 388-845-3030 | What items are assessed to determine my respite allocation? [Statutory Authority: RCW 71A.12.030, | |
| | | 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3030, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. |
| | | 388-845-3035 |
| | | How is the waiver respite assessment scored? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3035, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. |
| | | 388-845-3040 |
| | | When will the new respite assessment go into effect? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3040, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. |
| | | 388-845-3045 |
| | | How will I know the results of my respite assessment? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3045, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. |
| | | 388-845-3050 |
| | | What is the effective date of my respite allocation? [Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3050, filed 12/13/05, effective 1/13/06.] Repealed by 07-20-050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. |

WAC 388-845-0001 Definitions. "ADSA" means the aging and disability services administration, an administration within the department of social and health services.

"Aggregate services" means a combination of services subject to the dollar limitations in the Basic and Basic Plus waivers.

"CAP waiver" means the community alternatives program waiver.

"CARE" means the comprehensive assessment and reporting evaluation.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration of the department of social and health services.

"DDD assessment" refers to the standardized assessment tool as defined in chapter 388-828 WAC, used by DDD to measure the support needs of persons with developmental disabilities.

"Department" means the department of social and health services.

"Employment/day program services" means community access, person-to-person, prevocational services or supported employment services subject to the dollar limitations in the Basic and Basic Plus waivers.

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse, natural, adoptive or step parents; grandparents; brother; sister; step-brother; stepsister; uncle; aunt; first cousin; niece; or nephew.

"HCBS waivers" means home and community based services waivers.

"Home" means your present or intended place of residence.

"ICF/MR" means an intermediate care facility for the mentally retarded.

"Individual support plan (ISP)" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Legal representative" means a parent of a person who is under eighteen years of age, a person's legal guardian, a person's limited guardian when the subject matter is within the scope of limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Necessary supplemental accommodation representative" means an individual who receives copies of DDD planned action notices (PANs) and other department correspondence in order to help a client understand the documents and exercise the client's rights. A necessary supplemental accommodation representative is identified by a client of DDD when the client does not have a legal guardian and the client is requesting or receiving DDD services.

"Plan of care (POC)" means the primary tool DDD uses to determine and document your needs and to identify services to meet those needs until the DDD assessment is administered and the individual support plan is developed.

"Providers" means an individual or agency who meets the provider qualifications and is contracted with ADSA to provide services to you.

"Respite assessment" means an algorithm within the DDD assessment that determines the number of hours of respite care you may receive per year if you are enrolled in the Basic, Basic Plus, or Core waiver.

"SSI" means Supplemental Security Income, an assistance program administered by the federal Social Security Administration for blind, disabled and aged individuals.

"SSP" means state supplementary payment, a benefit administered by the department intended to augment an individual's SSI.

"State funded services" means services that are funded entirely with state dollars.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0001, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0001, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0015 What HCBS waivers are provided by the division of developmental disabilities (DDD)? DDD provides services through four HCBS waivers:

- (1) Basic waiver;
- (2) Basic Plus waiver;
- (3) CORE waiver; and
- (4) Community protection waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0015, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0030 Do I meet criteria for HCBS waiver-funded services? You meet criteria for DDD HCBS waiver-funded services if you meet all of the following:

- (1) You have been determined eligible for DDD services per RCW 71A.10.020(3).
- (2) You have been determined to meet ICF/MR level of care per WAC 388-845-0070, 388-828-3060 and 388-828-3080.
- (3) You meet disability criteria established in the Social Security Act.

(4) You meet financial eligibility requirements as defined in WAC 388-515-1510.

(5) You choose to receive services in the community rather than in an ICF/MR facility.

(6) You have a need for waiver services as identified in your plan of care or individual support plan.

(7) You are not residing in hospital, jail, prison, nursing facility, ICF/MR, or other institution.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0030, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0030, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0031 Can I be enrolled in more than one HCBS waiver? You cannot be enrolled in more than one HCBS waiver at the same time.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0031, filed 9/26/07, effective 10/27/07.]

WAC 388-845-0035 Am I guaranteed placement on a waiver if I meet waiver criteria? (1) If you are not currently enrolled in a waiver, meeting criteria for the waiver does not guarantee access to or receipt of waiver services.

(2) If you are currently on a waiver and you have been determined to have health and welfare needs that can be met only by services available on a different waiver, you are not guaranteed enrollment in that different waiver.

(3) WAC 388-845-0041, 388-845-3080 and 388-845-3085 describe DDD's responsibilities to provide services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0035, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0035, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0040 Is there a limit to the number of people who can be enrolled in each HCBS waiver? Each waiver has a capacity limit on the number of people who can be served in a waiver year. In addition, DDD has the authority to limit capacity based on availability of funding for new waiver participants.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0040, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0040, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0041 What is DDD's responsibility to provide my services under the waivers administered by DDD? If you are enrolled in an HCBS waiver administered by DDD, DDD must meet your assessed needs for health and welfare.

(1) DDD must address your assessed health and welfare needs in your plan of care or the individual support plan, as specified in WAC 388-845-3055.

(2) You have access to DDD paid services that are provided within the scope of your waiver, subject to the limitations in WAC 388-845-0110 and 388-845-0115.

(3) DDD will provide waiver services you need and qualify for within your waiver.

(4) DDD will not deny or limit your waiver services based on a lack of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0041, filed 9/26/07, effective 10/27/07. Statutory

Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0041, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0045 When there is capacity to add people to a waiver, how does DDD determine who will be enrolled? When there is capacity on a waiver and available funding for new waiver participants, DDD may enroll people from the statewide data base in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDD may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDD has determined to be in immediate risk of ICF/MR admission due to unmet health and welfare needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state-only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility per WAC 388-845-0060(9).

(3) For the Basic waiver only, DDD may consider persons who need the waiver services available in the Basic waiver to maintain them in their family's home.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0045, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0045, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0050 How do I request to be enrolled in a waiver? (1) You can contact DDD and request to be enrolled in a waiver or to enroll in a different waiver at any time.

(2) If you are assessed as meeting ICF/MR level of care as defined in WAC 388-845-0070 and chapter 388-828 WAC, your request for waiver enrollment will be documented by DDD in a statewide data base.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0050, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0050, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0052 What is the process if I am already on a waiver and request enrollment onto a different waiver? (1) If you are already enrolled in a DDD HCBS waiver and you request to be enrolled in a different waiver DDD will do the following:

(a) Assess your needs to determine whether your health and welfare needs can be met with services available on your current waiver or whether those needs can only be met through services offered on a different waiver.

(b) If DDD determines your health and welfare needs can be met by services available on your current waiver your enrollment request will be denied.

(c) If DDD determines your health and welfare needs can only be met by services available on a different waiver your service need will be reflected in your ISP.

(d) If DDD determines there is capacity on the waiver that is determined to meet your needs, DDD will place you on that waiver.

(2) You will be notified in writing of DDD's decision under subsection (1)(a) of this section and if your health and welfare needs cannot be met on your current waiver, DDD will notify you in writing whether there is capacity on the waiver that will meet your health and welfare needs and whether you will be enrolled on that waiver. If current capacity on that waiver does not exist, your eligibility for enrollment onto that different waiver will be tracked on a statewide data base.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0052, filed 9/26/07, effective 10/27/07.]

WAC 388-845-0055 How do I remain eligible for the waiver? Once you are enrolled in a DDD HCBS waiver, you can remain eligible if you continue to meet eligibility criteria in WAC 388-845-0030.

(1) DDD completes a reassessment at least every twelve months to determine if you continue to meet all of these eligibility requirements; and

(2) You must either receive a waiver service at least once in every thirty consecutive days, as specified in WAC 388-513-1320 (3)(b) or your health and welfare needs require monthly monitoring, which will be documented in your client record; and

(3) Your DDD assessment/reassessment interview must be administered in person and in your home. See WAC 388-828-1520.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0055, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0055, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0060 Can my waiver enrollment be terminated? DDD may terminate your waiver enrollment if DDD determines that:

(1) Your health and welfare needs cannot be met in your current waiver or for one of the following reasons:

(a) You no longer meet one or more of the requirements listed in WAC 388-845-0030;

(b) You do not have an identified need for a waiver service at the time of your annual plan of care or individual support plan;

(c) You do not use a waiver service at least once in every thirty consecutive days and your health and welfare do not require monthly monitoring;

(d) You are on the community protection waiver and choose not to be served by a certified residential community protection provider-intensive supported living services (CP-ISLS);

(e) You choose to disenroll from the waiver;

(f) You reside out-of-state;

(g) You cannot be located or do not make yourself available for the annual waiver reassessment of eligibility;

(h) You refuse to participate with DDD in:

(i) Service planning;

(ii) Required quality assurance and program monitoring activities; or

(iii) Accepting services agreed to in your plan of care or individual support plan as necessary to meet your health and welfare needs.

(i) You are residing in a hospital, jail, prison, nursing facility, ICF/MR, or other institution and remain in residence at least one full calendar month, and are still in residence:

(i) At the end of the twelfth month following the effective date of your current plan of care or individual support plan, as described in WAC 388-845-3060; or

(ii) On March 31st, the end of the waiver fiscal year, whichever date occurs first.

(j) Your needs exceed the maximum funding level or scope of services under the Basic or Basic Plus waiver as specified in WAC 388-845-3080; or

(k) Your needs exceed what can be provided under the CORE or community protection waiver as specified in WAC 388-845-3085; or

(2) Services offered on a different waiver can meet your health and welfare needs and DDD enrolls you on a different waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0060, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0060, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0070 What determines if I need ICF/MR level of care? DDD determines if you need ICF/MR level of care based on your need for waiver services. To reach this decision, DDD uses the DDD assessment as specified in chapter 388-828 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0070, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0070, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0100 What determines which waiver I am assigned to? If there is capacity, DDD will assign you to the waiver with the minimum service package necessary to meet your health and welfare needs, based on its evaluation of your DDD assessment as described in chapter 388-828 WAC and the following criteria:

(1) For the Basic waiver:

(a) You must live with your family or in your own home;

(b) Your family/caregiver's ability to continue caring for you can be maintained with the addition of services provided in the Basic waiver; and

(c) You do not need out-of-home residential services.

(2) For the Basic Plus waiver, your health and welfare needs exceed the amount allowed in the Basic waiver or require a service that is not contained in the Basic waiver; and

(a) You are at high risk of out-of-home placement or loss of your current living situation; or

(b) You require out-of-home placement and your health and welfare needs can be met in an adult family home or adult residential care facility.

(3) For the Core waiver:

(a) You are at immediate risk of out-of-home placement; and/or

(b) You have an identified health and welfare need for residential services that cannot be met by the Basic Plus waiver.

(4) For the community protection waiver, refer to WAC 388-845-0105.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0100, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0105 What criteria determine assignment to the community protection waiver? DDD may assign you to the community protection waiver only if you are at least eighteen years of age, not currently residing in a hospital, jail or other institution, and meet the following criteria:

(1) You have been identified by DDD as a person who meets one or more of the following:

(a) You have been convicted of or charged with a crime of sexual violence as defined in chapter 71.09 RCW;

(b) You have been convicted of or charged with acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or persons of casual acquaintance with whom no substantial personal relationship exists;

(c) You have been convicted of or charged with a sexually violent offense and/or predatory act, and may constitute a future danger as determined by a qualified professional;

(d) You have not been convicted and/or charged, but you have a history of stalking, sexually violent, predatory and/or opportunistic behavior which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors that may escalate to violence, as determined by a qualified professional; or

(e) You have committed one or more violent offense, as defined in RCW 9.94A.030.

(2) You receive or agree to receive residential services from certified residential community protection provider-intensive supported living services (CP-ISLS); and

(3) You comply with the specialized supports and restrictions in your:

(a) Plan of care or individual support plan;

(b) Individual instruction and support plan (IISP); and/or

(c) Treatment plan provided by DDD approved certified individuals and agencies.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0105, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0110 Are there limitations to the waiver services I can receive? There are limitations to waiver services. In addition to the limitations to your access to nonwaiver services cited for specific services in WAC 388-845-0115, the following limitations apply:

(1) A service must be offered in your waiver and authorized in your plan of care or individual support plan.

(2) Mental health stabilization services may be added to your plan of care or individual support plan after the services are provided.

(3) Waiver services are limited to services required to prevent ICF/MR placement.

(4) The cost of your waiver services cannot exceed the average daily cost of care in an ICF/MR.

(5) Waiver services cannot replace or duplicate other available paid or unpaid supports or services.

(6) Waiver funding cannot be authorized for treatments determined by DSHS to be experimental.

(7) The Basic and Basic Plus waivers have yearly limits on some services and combinations of services. The combination of services is referred to as aggregate services or employment/day program services.

(8) Your choice of qualified providers and services is limited to the most cost effective option that meets your health and welfare needs.

(9) Services provided out-of-state, other than in recognized bordering cities, are limited to respite care and personal care during vacations.

(a) You may receive services in a recognized out-of-state bordering city on the same basis as in-state services.

(b) The only recognized bordering cities are:

(i) Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston, Idaho; and

(ii) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria, Oregon.

(10) Other out-of-state waiver services require an approved exception to rule before DDD can authorize payment.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0110, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0111 Are there limitations regarding who can provide services? The following limitations apply to providers for waiver services:

(1) Your spouse cannot be your paid provider for any waiver service.

(2) If you are under age eighteen, your natural, step, or adoptive parent cannot be your paid provider for any waiver service.

(3) If you are age eighteen or older, your natural, step, or adoptive parent cannot be your paid provider for any waiver service with the exception of:

(a) Personal care;

(b) Transportation to and from a waiver service;

(c) Residential habilitation services per WAC 388-845-1510 if your parent is certified as a residential agency per chapter 388-101 WAC; or

(d) Respite care if you and the parent who provides the respite care live in separate homes.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0111, filed 9/26/07, effective 10/27/07.]

WAC 388-845-0200 What waiver services are available to me? Each of the four HCBS waivers has a different scope of service and your plan of care or individual support plan defines the waiver services available to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0200, filed 9/26/07, effective 10/27/07. Statutory

Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0205 Basic waiver services.

| BASIC WAIVER | SERVICES | YEARLY LIMIT |
|--------------|--|---|
| | AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy Physical therapy Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation | May not exceed \$1454 per year on any combination of these services |
| | EMPLOYMENT/DAY PROGRAM SERVICES: Community access Person-to-person Prevocational services Supported employment | May not exceed \$6631 per year |
| | Sexual deviancy evaluation | Limits are determined by DDD |
| | Respite care | Limits are determined by the DDD assessment |
| | Personal care | Limits are determined by the CARE tool used as part of the DDD assessment |
| | MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services | Limits are determined by a mental health professional or DDD |
| | Emergency assistance is only for aggregate services and/or employment/day program services contained in the Basic waiver | \$6000 per year; Preauthorization required |

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0205, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 07-05-014, § 388-845-0205, filed 2/9/07, effective 3/12/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0205, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0210 Basic Plus waiver services.

| BASIC PLUS WAIVER | SERVICES | YEARLY LIMIT |
|-------------------|---|---|
| | AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy Physical therapy Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation | May not exceed \$6192 per year on any combination of these services |
| | EMPLOYMENT/DAY PROGRAM SERVICES: Community access Person-to-person Prevocational services Supported employment | May not exceed \$9691 per year |
| | Adult foster care (adult family home) Adult residential care (boarding home) | Determined per department rate structure |
| | MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services | Limits determined by a mental health professional or DDD |
| | Personal care | Limits determined by the CARE tool used as part of the DDD assessment |
| | Respite care | Limits are determined by the DDD assessment |
| | Sexual deviancy evaluation | Limits are determined by DDD |
| | Emergency assistance is only for aggregate services and/or employment/day program services contained in the Basic Plus waiver | \$6000 per year; Preauthorization required |

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0210, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.120. 07-05-014, § 388-845-0210, filed 2/9/07, effective 3/12/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0210, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0215 CORE waiver services.

| CORE WAIVER | SERVICES | YEARLY LIMIT |
|-------------|--|--|
| | Behavior management and consultation Community guide Community transition Environmental accessibility adaptations Occupational therapy Sexual deviancy evaluation Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation | Determined by the plan of care or individual support plan, not to exceed the average cost of an ICF/MR for any combination of services |
| | Residential habilitation | |
| | Community access Person-to-person Prevocational services Supported employment | |
| | MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services | Limits determined by a mental health professional or DDD |
| | Personal care | Limits determined by the CARE tool used as part of the DDD assessment |
| | Respite care | Limits are determined by the DDD assessment |

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0215, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0215, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0220 Community protection waiver services.

| COMMUNITY PROTECTION WAIVER | SERVICES | YEARLY LIMIT |
|-----------------------------|--|--|
| | Behavior management and consultation Community transition | Determined by the plan of care or individual support |

| COMMUNITY PROTECTION WAIVER | SERVICES | YEARLY LIMIT |
|-----------------------------|---|---|
| | Environmental accessibility adaptations Occupational therapy Physical therapy Sexual deviancy evaluation Skilled nursing Specialized medical equipment and supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation Residential habilitation Person-to-person Prevocational services Supported employment | plan, not to exceed the average cost of an ICF/MR for any combination of services |
| | MENTAL HEALTH STABILIZATION SERVICES: Behavioral management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services | Limits determined by a mental health professional or DDD |

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0220, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0220, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0510 Are there limits to the behavior management and consultation I can receive? The following limits apply to your receipt of behavior management and consultation:

- (1) DDD and the treating professional will determine the need and amount of service you will receive, subject to the limitations in subsection (2) below.
- (2) The dollar limitations for aggregate services in your Basic and Basic Plus waiver limit the amount of service unless provided as a mental health stabilization service.
- (3) DDD reserves the right to require a second opinion from a department-selected provider.
- (4) Behavior management and consultation not provided as a mental health stabilization service requires prior approval by the DDD regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0510, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0510, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0800 What is emergency assistance? Emergency assistance is a temporary increase to the yearly aggregate services and/or employment/day program services dollar limit specified in the Basic and Basic Plus waiver when

additional waiver services are required to prevent ICF/MR placement. These additional services are limited to the services provided in your waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0800, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0800, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0820 Are there limits to my use of emergency assistance? All of the following limitations apply to your use of emergency assistance:

- (1) Prior approval by the DDD regional administrator or designee is required based on a reassessment of your plan of care or individual support plan to determine the need for emergency services;
- (2) Payment authorizations are reviewed every thirty days and cannot exceed six thousand dollars per twelve months based on the effective date of your current plan of care or individual support plan;
- (3) Emergency assistance services are limited to the aggregate services and employment/day program services in the Basic and Basic Plus waivers;
- (4) Emergency assistance may be used for interim services until:
 - (a) The emergency situation has been resolved; or
 - (b) You are transferred to alternative supports that meet your assessed needs; or
 - (c) You are transferred to an alternate waiver that provides the service you need.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0820, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0820, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0900 What are environmental accessibility adaptations? (1) Environmental accessibility adaptations are available in all of the HCBS waivers and provide the physical adaptations to the home required by the individual's plan of care or individual support plan needed to:

- (a) Ensure the health, welfare and safety of the individual; or
- (b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.
- (2) Environmental accessibility adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0900, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0910 What limitations apply to environmental accessibility adaptations? The following service limitations apply to environmental accessibility adaptations:

- (1) Environmental accessibility adaptations require prior approval by the DDD regional administrator or designee.
- (2) Environmental accessibility adaptations or improvements to the home are excluded if they are of general utility

without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

(3) Environmental accessibility adaptations cannot add to the total square footage of the home.

(4) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-0910, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0910, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1300 What are personal care services? Personal care services as defined in WAC 388-106-0010 are the provision of assistance with personal care tasks. These services are available in the Basic, Basic Plus, and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1300, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1300, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1310 Are there limits to the personal care services I can receive? (1) You must meet the programmatic eligibility for Medicaid personal care in chapters 388-106 and 388-71 WAC governing Medicaid personal care (MPC) using the current department approved assessment form: Comprehensive assessment reporting evaluation (CARE).

(2) The maximum hours of personal care you may receive are determined by the CARE tool used as part of the DDD assessment.

(a) Provider rates are limited to the department established hourly rates for in-home Medicaid personal care.

(b) Homecare agencies must be licensed through the department of health and contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1310, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1310, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1505 Who are qualified providers of residential habilitation services for the CORE waiver? Providers of residential habilitation services for participants in the CORE waiver must be one of the following:

(1) Individuals contracted with DDD to provide residential support as a "companion home" provider;

(2) Individuals contracted with DDD to provide training as an "alternative living provider";

(3) Agencies contracted with DDD and certified per chapter 388-101 WAC;

(4) State-operated living alternatives (SOLA);

(5) Licensed and contracted group care homes, foster homes, child placing agencies or staffed residential homes per chapter 388-148 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1505, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1505, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1515 Are there limits to the residential habilitation services I can receive? (1) You may only receive one type of residential habilitation service at a time.

(2) None of the following can be paid for under the CORE or community protection waiver:

(a) Room and board;

(b) The cost of building maintenance, upkeep, improvement, modifications or adaptations required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code;

(c) Activities or supervision already being paid for by another source;

(d) Services provided in your parent's home unless you are receiving alternative living services for a maximum of six months to transition you from your parent's home into your own home.

(3) Alternative living services in the CORE waiver cannot:

(a) Exceed forty hours per month;

(b) Provide personal care or protective supervision.

(4) The following persons cannot be paid providers for your service:

(a) Your spouse;

(b) Your natural, step, or adoptive parents if you are a child age seventeen or younger;

(c) Your natural, step, or adoptive parent unless your parent is certified as a residential agency per chapter 388-101 WAC or is employed by a certified or licensed agency qualified to provide residential habilitation services.

(5) The initial authorization of residential habilitation services requires prior approval by the DDD regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1515, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1515, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1610 Where can respite care be provided? (1) Respite care can be provided in the following location(s):

(a) Individual's home or place of residence;

(b) Relative's home;

(c) Licensed children's foster home;

(d) Licensed, contracted and DDD certified group home;

(e) Licensed boarding home contracted as an adult residential center;

(f) Adult residential rehabilitation center;

(g) Licensed and contracted adult family home;

(h) Children's licensed group home, licensed staffed residential home, or licensed childcare center;

(i) Other community settings such as camp, senior center, or adult day care center.

(2) Additionally, your respite care provider may take you into the community while providing respite services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1610, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1610, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1615 Who are qualified providers of respite care? Providers of respite care can be any of the fol-

lowing individuals or agencies contracted with DDD for respite care:

- (1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
- (2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
- (3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
- (4) Licensed and contracted adult family home;
- (5) Licensed and contracted adult residential care facility;
- (6) Licensed and contracted adult residential treatment facility under chapter 246-337 WAC;
- (7) Licensed childcare center under chapter 170-295 WAC;
- (8) Licensed child daycare center under chapter 170-295 WAC;
- (9) Adult daycare centers contracted with DDD;
- (10) Certified provider under chapter 388-101 WAC when respite is provided within the DDD contract for certified residential services; or
- (11) Other DDD contracted providers such as community center, senior center, parks and recreation, summer programs, adult day care.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1615, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1615, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1620 Are there limits to the respite care I can receive? The following limitations apply to the respite care you can receive:

- (1) The DDD assessment will determine how much respite you can receive per chapter 388-828 WAC.
- (2) Prior approval by the DDD regional administrator or designee is required:
 - (a) To exceed fourteen days of respite care per month; or
 - (b) To pay for more than eight hours in a twenty-four hour period of time for respite care in any setting other than your home or place of residence. This limitation does not prohibit your respite care provider from taking you into the community, per WAC 388-845-1610(2).
- (3) Respite cannot replace:
 - (a) Daycare while a parent or guardian is at work; and/or
 - (b) Personal care hours available to you. When determining your unmet need, DDD will first consider the personal care hours available to you.
- (4) Respite providers have the following limitations and requirements:
 - (a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;
 - (b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and
 - (c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.
- (5) Your caregiver cannot provide paid respite services for you or other persons during your respite care hours.

(6) DDD cannot pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

(7) If you require respite from a licensed practical nurse (LPN) or a registered nurse (RN), services may be authorized as skilled nursing services per WAC 388-845-1700 using an LPN or RN. If you are in the Basic Plus waiver, skilled nursing services are limited to the dollar limits of your aggregate services per WAC 388-845-0210.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1620, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1620, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1660 Are there limitations to the sexual deviation evaluations I can receive? (1) The evaluations must meet the standards contained in WAC 246-930-320.

(2) Sexual deviation evaluations require prior approval by the DDD regional administrator or designee.

(3) The costs of sexual deviation evaluations do not count toward the dollar limits for aggregate services in the Basic or Basic Plus waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1660, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1660, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1710 Are there limitations to the skilled nursing services I can receive? The following limitations apply to your receipt of skilled nursing services:

(1) Skilled nursing services require prior approval by the DDD regional administrator or designee.

(2) DDD and the treating professional determine the need for and amount of service.

(3) DDD reserves the right to require a second opinion by a department-selected provider.

(4) The dollar limitation for aggregate services in your Basic Plus waiver limit the amount of skilled nursing services unless provided as a mental health stabilization service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1710, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1710, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1800 What are specialized medical equipment and supplies? (1) Specialized medical equipment and supplies are durable and nondurable medical equipment not available through Medicaid or the state plan which enables individuals to:

(a) Increase their abilities to perform their activities of daily living; or

(b) Perceive, control or communicate with the environment in which they live.

(2) Durable and nondurable medical equipment are defined in WAC 388-543-1000 and 388-543-2800 respectively.

(3) Also included are items necessary for life support; and ancillary supplies and equipment necessary to the proper functioning of the equipment and supplies described in subsection (1) above.

(4) Specialized medical equipment and supplies are available in all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1800, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1800, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1810 Are there limitations to my receipt of specialized medical equipment and supplies? The following limitations apply to your receipt of specialized medical equipment and supplies:

- (1) Specialized medical equipment and supplies require prior approval by the DDD regional administrator or designee for each authorization.
- (2) DDD reserves the right to require a second opinion by a department-selected provider.
- (3) Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan.
- (4) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.
- (5) Medications, prescribed or nonprescribed, and vitamins are excluded.
- (6) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1810, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1810, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1910 Are there limitations to the specialized psychiatric services I can receive? (1) Specialized psychiatric services are excluded if they are available through other Medicaid programs.

- (2) The dollar limitations for aggregate service in your Basic and Basic Plus waiver limit the amount of specialized psychiatric services unless provided as a mental health stabilization service.
- (3) Specialized psychiatric services require prior approval by the DDD regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-1910, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1910, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2000 What is staff/family consultation and training? (1) Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person. This service is available in all four HCBS waivers.

- (2) Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the individual's plan of care or individual support plan, including:
 - (a) Health and medication monitoring;
 - (b) Positioning and transfer;
 - (c) Basic and advanced instructional techniques;
 - (d) Positive behavior support; and
 - (e) Augmentative communication systems.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-2000, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training? To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDD:

- (1) Audiologist;
- (2) Licensed practical nurse;
- (3) Marriage and family therapist;
- (4) Mental health counselor;
- (5) Occupational therapist;
- (6) Physical therapist;
- (7) Registered nurse;
- (8) Sex offender treatment provider;
- (9) Speech/language pathologist;
- (10) Social worker;
- (11) Psychologist;
- (12) Certified American sign language instructor;
- (13) Nutritionist;
- (14) Registered counselor;
- (15) Certified dietician; or
- (16) Recreation therapist certified by the National Council for Therapeutic Recreation.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-2005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2010 Are there limitations to the staff/family consultation and training I can receive? (1) Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation and training.

- (2) Staff/family consultation and training require prior approval by the DDD regional administrator or designee.
- (3) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-2010, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2200 What are transportation services? Transportation services provide reimbursement to a provider when the transportation is required and specified in the waiver plan of care or individual support plan. This service is available in all four HCBS waivers if the cost and responsibility for transportation is not already included in your provider's contract and payment.

- (1) Transportation provides you access to waiver services, specified by your plan of care or individual support plan.
- (2) Whenever possible, you must use family, neighbors, friends, or community agencies that can provide this service without charge.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-2200, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2210 Are there limitations to the transportation services I can receive? The following limitations apply to transportation services:

(1) Transportation to/from medical or medically related appointments is a Medicaid transportation service and is to be considered and used first.

(2) Transportation is offered in addition to medical transportation but cannot replace Medicaid transportation services.

(3) Transportation is limited to travel to and from a waiver service.

(4) Transportation does not include the purchase of a bus pass.

(5) Reimbursement for provider mileage requires prior approval by DDD and is paid according to contract.

(6) This service does not cover the purchase or lease of vehicles.

(7) Reimbursement for provider travel time is not included in this service.

(8) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

(9) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your provider's contract and payment.

(10) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

(11) Transportation services require prior approval by the DDD regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-2210, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2210, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3000 What is the process for determining the services I need? Your service needs are determined through the DDD assessment and the service planning process as defined in chapter 388-828 WAC. Only identified health and welfare needs will be authorized for payment in the ISP.

(1) You receive an initial and annual assessment of your needs using a department-approved form.

(a) You meet the eligibility requirements for ICF/MR level of care.

(b) The "comprehensive assessment reporting evaluation (CARE)" tool will determine your eligibility and amount of personal care services.

(c) If you are in the Basic, Basic Plus or CORE waiver, the DDD assessment will determine the amount of respite care available to you.

(2) From the assessment, DDD develops your waiver plan of care or individual support plan (ISP) with you and/or your legal representative and others who are involved in your life such as your parent or guardian, advocate and service providers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3000, filed 9/26/07, effective 10/27/07. Statutory

Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3055 What is a waiver individual support plan (ISP)? (1) The individual support plan (ISP) replaces the plan of care and is the primary tool DDD uses to determine and document your needs and to identify the services to meet those needs. Your plan of care remains in effect until a new ISP is developed.

(2) Your ISP must include:

(a) Your identified health and welfare needs;

(b) Both paid and unpaid services approved to meet your identified health and welfare needs as identified in WAC 388-828-8040 and 388-828-8060; and

(c) How often you will receive each waiver service; how long you will need it; and who will provide it.

(3) For an initial ISP, you or your legal representative must sign or give verbal consent to the plan indicating your agreement to the receipt of services.

(4) For a reassessment or review of your ISP, you or your legal representative must sign or give verbal consent to the plan indicating your agreement to the receipt of services.

(5) You may choose any qualified provider for the service, who meets all of the following:

(a) Is able to meet your needs within the scope of their contract, licensure and certification;

(b) Is reasonably available;

(c) Meets provider qualifications in chapters 388-845 and 388-825 WAC for contracting; and

(d) Agrees to provide the service at department rates.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3055, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3055, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3056 What if I need assistance to understand my plan of care or individual support plan? If you are unable to understand your plan of care or individual support plan and the individual who has agreed to provide assistance to you as your necessary supplemental accommodation representative is unable to assist you with understanding your individual support plan, DDD will take the following steps:

(1) Consult with the office of the attorney general to determine if you require a legal representative or guardian to assist you with your plan of care or individual support plan.

(2) Continue your current waiver services.

(3) If the office of the attorney general or a court determines that you do not need a legal representative, DDD will continue to try to provide necessary supplemental accommodations in order to help you understand your plan of care or individual support plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3056, filed 9/26/07, effective 10/27/07.]

WAC 388-845-3060 When is my plan of care or individual support plan effective? (1) For an initial plan of care or individual support plan, the plan is effective the date DDD signs and approves it after a signature or verbal consent is obtained.

(2) For a reassessment or review of a plan of care or individual support plan, the plan is effective the date DDD signs and approves it after a signature or verbal consent is obtained.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3060, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3060, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3061 Can a change in my plan of care or individual support plan be effective before I sign it? If you verbally request a change in service to occur immediately, DDD can sign the plan of care or individual support plan and approve it prior to receiving your signature.

(1) Your plan of care or individual support plan will be mailed to you for signature.

(2) You retain the same appeal rights as if you had signed the plan of care or individual support plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3061, filed 9/26/07, effective 10/27/07.]

WAC 388-845-3062 Who is required to sign or give verbal consent to the plan of care or individual support plan? (1) If you do not have a legal representative, you must sign or give verbal consent to the plan of care or individual support plan.

(2) If you have a legal representative, your legal representative must sign or give verbal consent to the plan of care or individual support plan.

(3) If you need assistance to understand your plan of care or individual support plan, DDD will follow the steps outlined in WAC 388-845-3056 (1) and (3).

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3062, filed 9/26/07, effective 10/27/07.]

WAC 388-845-3065 How long is my plan effective?

(1) Your plan of care is effective until it is replaced by your individual support plan.

(2) Your individual support plan is effective through the last day of the twelfth month following the effective date or until another ISP is completed, whichever occurs sooner.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3065, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3065, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3070 What happens if I do not sign or verbally consent to my individual support plan (ISP)? If DDD is unable to obtain the necessary signature or verbal consent for an initial, reassessment or review of your individual support plan (ISP), DDD will take one or more of the following actions:

(1) If this individual support plan is an initial plan, DDD will be unable to provide waiver services. DDD will not assume consent for an initial plan and will follow the steps described in WAC 388-845-3056 (1) and (3).

(2) If this individual support plan is a reassessment or review and you are able to understand your ISP:

(a) DDD will continue providing services as identified in your most current plan of care or ISP until the end of the ten-day advance notice period as stated in WAC 388-825-105.

(b) At the end of the ten-day advance notice period, unless you file an appeal, DDD will assume consent and implement the new ISP without the required signature or verbal consent as defined in WAC 388-845-3062 above.

(3) If this individual support plan is a reassessment or review and you are not able to understand your ISP, DDD will continue your existing services and take the steps described in WAC 388-845-3056.

(4) You will be provided written notification and appeal rights to this action to implement the new ISP.

(5) Your appeal rights are in WAC 388-845-4000 and 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3070, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3070, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3075 What if my needs change? You may request a review of your plan of care or individual support plan at any time by calling your case manager. If there is a significant change in your condition or circumstances, DDD must reassess your plan of care or individual support plan with you and amend the plan to reflect any significant changes. This reassessment does not affect the end date of your annual plan of care or individual support plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3075, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3075, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3095 Will I have to pay toward the cost of waiver services? (1) You are required to pay toward board and room costs if you live in a licensed facility or in a companion home as room and board is not considered to be a waiver service.

(2) You will not be required to pay towards the cost of your waiver services if you receive SSI.

(3) You may be required to pay towards the cost of your waiver services if you do not receive SSI. DDD determines what amount, if any, you pay in accordance with WAC 388-515-1510.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-3095, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3095, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4000 What are my appeal rights under the waiver? In addition to your appeal rights under WAC 388-825-120, you have the right to appeal the following decisions:

(1) Disenrollment from a waiver under WAC 388-845-0060, including a disenrollment from a waiver and enrollment in a different waiver.

(2) A denial of your request to receive ICF/MR services instead of waiver services; or

(3) A denial of your request to be enrolled in a waiver, subject to the limitations described in WAC 388-845-4005.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-4000, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4005 Can I appeal a denial of my request to be enrolled in a waiver? (1) If you are not enrolled in a waiver and your request to be enrolled in a waiver is denied, your appeal rights are limited to the decision that you are not eligible to have your request documented in a statewide data base because you do not need ICF/MR level of care per WAC 388-845-0070, 388-828-8040 and 388-828-8060.

(2) If you are enrolled in a waiver and your request to be enrolled in a different waiver is denied, your appeal rights are limited to DDD's decision that the services contained in a different waiver are not necessary to meet your health and welfare needs and that the services available on your current waiver can meet your health and welfare needs.

(3) If DDD determines that the services offered in a different waiver are necessary to meet your health and welfare needs, but there is not capacity on the different waiver, you do not have the right to appeal any denial of enrollment on a different waiver when DDD determines there is not capacity to enroll you on a different waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 07-20-050, § 388-845-4005, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4005, filed 12/13/05, effective 1/13/06.]

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

388-865-0420 Intake evaluation.

WAC 388-865-0420 Intake evaluation. (1) The intake evaluation or brief intake evaluation must be provided by a mental health professional and:

- (a) Be initiated prior to the provision of any noncrisis mental health services;
- (b) Be initiated within ten working days of the request for services;
- (c) Be developed in collaboration with the consumer;
- (d) Be inclusive of input of people who provide active support to the consumer, if the consumer requests or if the consumer is under age thirteen;
- (e) Be completed within thirty working days of the initiation of the intake evaluation; and
- (f) Include a consent for treatment or a copy of detention or involuntary treatment order.

(2) Except as when a brief intake evaluation as described in WAC 388-865-0420(4) is provided, a full intake evaluation must include:

- (a) A description of the presenting problem, presented needs;
- (b) A description of the consumer's and family's strengths;
- (c) Consumer's needs and desired outcomes in the consumer's own words;
- (d) Consumer's culture/cultural history (including, but not limited to, ethnicity or race, and religion);
- (e) History of other disorders, substance/alcohol abuse, developmental disability, any other relevant disability, and treatment, if any;

(f) Medical history, hospitalizations, treatment, past and current medications;

(g) Mental health services history, past and current medication;

(h) Assessment of suicide/homicide and self harm risk. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(i) Sufficient information to justify the provisional diagnosis;

(j) Documentation showing the consumer has been asked if they are under the supervision of the department of corrections or juvenile court;

(k) If the consumer is a child:

(i) Developmental history;

(ii) Parental goals and desired outcomes (if consent is obtained or not required due to age or state custody); and

(iii) Family and/or placement issues, including, if appropriate, family dynamics, placement disruptions, and current placement needs.

(3) If seeking any of the information required in subsection (2) of this section presents a barrier to the provision of services for the consumer, any portion of the intake may be left incomplete providing the reason for the omission is clearly documented in the clinical record.

(4) A brief intake evaluation may be used when it is reasonably believed services to the consumer will be completed within a six-month period. A brief intake evaluation may also be substituted for a full intake evaluation if a consumer is resuming services after being out of services for a period of less than twelve months and had received a full intake evaluation as part of the previous service provision. A brief intake evaluation must include:

(a) A description of presenting problem, presented needs, desired outcomes, and consumer strengths identified by both the consumer and the clinician;

(b) Sufficient information to justify the provisional diagnosis;

(c) The consumer's current physician and prescribed medications;

(d) Current and historical substance use/abuse or other co-occurring disorders including developmental disabilities;

(e) Mental health services history including past and current medications;

(f) Assessment of suicide/homicide and self-harm risk. A referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, must be made if indicated in the risk assessment;

(g) Documentation that the consumer has been asked if they are under the supervision by the department of corrections or juvenile court; and

(h) Identification of mutually agreed upon outcomes that are expected to be accomplished within the six-month period that will be the treatment plan. This treatment plan will be used in place of the treatment plan required in WAC 388-865-0425.

(5) In cases where a consumer initially receives services based on a brief intake evaluation, the community support service provider must complete the additional elements required in a full intake evaluation if the consumer is expected to continue to receive services after six months. In

these cases a treatment plan must be developed that meets all the requirements of WAC 388-865-0425.

(6) If seeking any of the information required in subsection (4) of this section presents a barrier to the provision of services for the consumer, any portion of the intake may be left incomplete providing the reason for the omission is clearly documented in the clinical record.

[Statutory Authority: RCW 71.24.035, 07-06-050, § 388-865-0420, filed 3/2/07, effective 4/2/07. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166, 05-14-082, § 388-865-0420, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

Chapter 388-891 WAC

VOCATIONAL REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 388-890 WAC (part))

WAC

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| 388-891-0103 | Can DVR obtain personal information about you? |
| 388-891-0140 | Can I obtain copies of information in my case service record? |
| 388-891-0255 | How do I request a fair hearing? |
| 388-891-0330 | Does DVR consider academic awards and scholarships based on merit as comparable benefits? |
| 388-891-0360 | What personal resources are not counted in the decision about whether I have to help pay for services? |
| 388-891-0520 | What are the criteria for priority category 1—Individuals with most severe disabilities? |
| 388-891-0530 | What are the criteria for priority category 2—Individuals with severe disabilities? |
| 388-891-0540 | What are the criteria for priority category 3—Individuals with disabilities? |
| 388-891-0840 | What are supported employment services? |
| 388-891-0880 | What if my counselor and I cannot secure a source of extended services or natural supports? |
| 388-891-1137 | What if the employment goal I choose is religious in nature? |
| 388-891-1300 | Why does DVR close a case service record? |

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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| 388-891-0870 | Are supported employment services time-limited? [Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW, 03-02-014, § 388-891-0870, filed 12/20/02, effective 2/3/03.] Repealed by 07-10-023, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363.] |
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WAC 388-891-0103 Can DVR obtain personal information about you? (1) In order to serve you, DVR may obtain personal information about you from service providers and cooperating agencies. This personal information helps us better understand your disabilities, barriers to employment, abilities, interests and needs for VR services and to coordinate DVR services with the services you receive from other agencies and programs.

(2) DVR may obtain financial information about you from state and federal agencies to verify benefits you receive from other agencies or programs, earnings and income from employment or self-employment. DVR will only collect such information if the state or federal agencies have legal author-

ity to release it to DVR. This may occur with or without your consent.

(3) If DVR collects information about you from service providers or other agencies, the information will not be released to others without your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, 07-10-023, § 388-891-0103, filed 4/23/07, effective 6/15/07.]

WAC 388-891-0140 Can I obtain copies of information in my case service record? (1) You may review or obtain copies of information contained in your case service record by submitting a request to DVR. DVR provides access to or provides copies of records upon request, except in the following circumstances:

(a) If DVR believes the medical, psychological, or other records in your case service record may be harmful to give to you, DVR only releases the records to a third party that you choose, such as your representative, parent, legal guardian or a qualified medical professional.

(b) If DVR receives personal information about you from another agency or service provider, DVR may share the records only by, or under the conditions established by the agency or service provider that provided the information.

(c) If a representative has been appointed by a court to represent you, the information must be released to the representative.

(2) DVR provides access or gives you copies of records within five business days of receiving your request. If DVR cannot fulfill your request within five business days, DVR will send you a written notice of the reason(s) the request cannot be met and the date you are granted access or the date the requested information will be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, 07-10-023, § 388-891-0140, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW, 03-02-014, § 388-891-0140, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0255 How do I request a fair hearing?

(1) To ask for a fair hearing, send a written request to the office of administrative hearings. You must include the following information in your written request:

- Your name, address, and telephone number;
- The name of the DSHS program that the fair hearing involves (such as DVR);
- A written statement describing the decision and the reasons you disagree; and
- Any other information or documents that relate to the matter.

(2) You must submit your request for a fair hearing within forty-five calendar days of the date the VR counselor makes the decision with which you disagree.

(3) You may ask any DVR employee for instructions or assistance to submit a request for a fair hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, 07-10-023, § 388-891-0255, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW

43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0255, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0330 Does DVR consider academic awards and scholarships based on merit as comparable benefits? DVR does not consider academic awards and scholarships based on merit as comparable benefits.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0330, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0330, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0360 What personal resources are not counted in the decision about whether I have to help pay for services? DVR does not count the following resources when deciding whether you need to help pay for DVR:

- (1) The value of your primary home and furnishings;
- (2) The value of items that you keep because of personal attachment, rather than because of monetary value;
- (3) The value of one vehicle per household member needed for work, school, or to participate in VR services;
- (4) Retirement, insurance, or trust accounts that do not pay a current benefit to you or your family;
- (5) If a retirement, insurance or trust account pays a current benefit, only the monthly benefit is counted as income and the balance of the account is excluded;
- (6) Up to five thousand dollars of your total assets are excluded as exempt;
- (7) Equipment or machinery used to produce income;
- (8) Livestock used to produce income; and
- (9) Disability-related items and/or services.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0360, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0360, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0520 What are the criteria for priority category 1—Individuals with most severe disabilities? DVR determines you are in priority category 1—Individuals with most severe disabilities, if you are determined eligible for vocational rehabilitation services and you meet the following criteria:

- (1) You require two or more VR services over an extended period of time (twelve months or more); and
- (2) You experience serious functional losses in four or more of the following areas in terms of an employment outcome:
 - (a) Mobility;
 - (b) Communication;
 - (c) Self-care;
 - (d) Cognition and learning (self-direction);
 - (e) Interpersonal;
 - (f) Work tolerance; or
 - (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0520, filed 4/23/07, effective 6/15/07. Statutory Authority:

RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0520, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0530 What are the criteria for priority category 2—Individuals with severe disabilities? DVR determines you are in priority category 2—Individuals with severe disabilities if you are determined eligible for vocational rehabilitation services and you meet the following criteria:

- (1) You require two or more VR services over an extended period of time (twelve months or more); and
- (2) You experience serious functional losses in one to three of the following areas in terms of an employment outcome:
 - (a) Mobility;
 - (b) Communication;
 - (c) Self-care;
 - (d) Cognition and learning (self-direction);
 - (e) Interpersonal;
 - (f) Work tolerance; or
 - (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0530, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0530, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0540 What are the criteria for priority category 3—Individuals with disabilities? DVR determines you are in priority category 3—Individuals with disabilities if you are determined eligible for vocational rehabilitation services, but you do not meet the criteria for priority category 1 or priority category 2.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0540, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0540, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0840 What are supported employment services? Supported employment services are:

- (1) Ongoing support services as described in WAC 388-891-0845; and
- (2) Vocational rehabilitation services listed in WAC 388-891-0600.
- (3) These services may be provided to you:
 - (a) As part of your individualized plan for employment;
 - (b) To support and maintain you in supported employment;
 - (c) For a period of time not to exceed eighteen months, unless under special circumstances, you and the VR counselor jointly agree to extend the time in order to achieve the employment goals in your rehabilitation plan for employment. This eighteen month period begins from job placement until transition to extended services.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-

023, § 388-891-0840, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0840, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0880 What if my counselor and I cannot secure a source of extended services or natural supports? If a DVR counselor determines that you require supported employment and has explored all available options for securing resources for extended services or natural supports and there is no reasonable expectation these services will become available, DVR must close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-0880, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0880, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1137 What if the employment goal I choose is religious in nature? DVR is prohibited from supporting education or training for an employment goal that is religious in nature under the Washington State Constitution, Article 1, Subsection 11.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-1137, filed 4/23/07, effective 6/15/07.]

WAC 388-891-1300 Why does DVR close a case service record? A DVR counselor closes your case service record for any of the following reasons:

- (1) You achieve an employment outcome;
- (2) DVR determines that you are not eligible or no longer eligible;
- (3) You are no longer available to participate in services;
- (4) You decline VR services;
- (5) You cannot be located;
- (6) You ask DVR to close your case service record;
- (7) You refuse to cooperate in required or agreed upon conditions or services; or
- (8) You require supported employment services and you and your VR counselor have explored all available options for securing resources for extended services or natural supports and there is no reasonable expectation these services will become available.

[Statutory Authority: RCW 74.29.020, 74.08.090, and August 1998 Amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363. 07-10-023, § 388-891-1300, filed 4/23/07, effective 6/15/07. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1300, filed 12/20/02, effective 2/3/03.]