Chapter 388-450A WAC
INCOME—GARNISHMENT

WAC

WAC 388-450A-0010 Can my subsidized income be garnished? (1) Your subsidized income cannot be garnished. Subsidized income is income that is partly or entirely paid from temporary assistance for needy families (TANF) funds. Examples of subsidized income are community jobs and WorkFirst work study.

(2) For how your subsidized income affects your benefits, see WAC 388-450-0035 or 388-450-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.280. 05-13-029, § 388-450A-0010, filed 6/3/05, effective 7/4/05.]

Chapter 388-452 WAC
INTERVIEW REQUIREMENTS

WAC

WAC 388-452-0005 Do I have to be interviewed in order to get benefits? (1) Unless you are applying for medical only, you or your authorized representative must have an interview with the department:

(a) At initial certification; and

(b) At least once every twelve months if your assistance unit (AU) is certified for twelve months or less.

(2) You do not have to attend an interview if you are applying for or recertifying medical benefits only. If we deny your application for cash or Basic Food because you did not have an interview, we continue to process your request for medical benefits.

(3) You will have just one interview even if you are applying for or are having a review for benefits from more than one program.

(4) If we do not interview you on the same day that we get your application, we schedule an interview appointment for you. We schedule your appointment the day we get your application or on the next business day if we get your application outside of our scheduled business hours, on a holiday or a weekend.

(5) We schedule an interview so your AU has at least ten days after the interview to provide needed verification:

(a) Before the end of the thirty-day processing period for applications; or

(b) Before your certification period ends for eligibility reviews or recertifications.

(6) If you miss your first interview and ask for another interview within thirty days of the date you applied for benefits, we schedule a second interview for you.

(7) If you must have an interview for benefits, you or someone who can give us the information we need about your AU must participate in the interview. You may bring any person you choose to your interview.

(8) You may choose someone to take your place in your interview:

(a) For cash assistance if you cannot come to the local office for us to decide if you are eligible for benefits; or

(b) For Basic Food if the person is your authorized representative as described in WAC 388-460-0005.

(9) We usually have interviews at the local office. You can have a scheduled telephone interview if there is **any reason** you cannot attend an interview at the local office. Examples of reasons you may be unable to attend an interview include:

(a) Your work or training schedule make it inconvenient for you to attend an in-office interview during regular business hours;

(b) You are unable to take time off of work to attend an in-office interview, because you would not get paid for this time or you fear you could lose your job;

(c) Someone in your AU is ill, or you have to stay home to care for an AU member;

(d) You are having transportation problems;

(e) You can't safely get to the office because of severe weather;

(f) You live in a remote area and can't easily get to the local office;

(g) All the people in your AU are elderly, mentally disabled, or physically disabled;

(h) Someone in your AU is affected by family violence such as physical or mental abuse, harassment, or stalking by the abuser; or

(i) You have **any other** situation that makes it difficult for you to come into the office for an interview.

(10) If you currently get benefits from the department and you are completing an eligibility review or recertification for ongoing benefits under chapter 388-434 WAC, you can have a scheduled phone interview even if you do not meet the requirements for a phone interview listed above.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-10-102, § 388-452-0005, filed 5/4/04, effective 7/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 7 C.F.R. 273.2(e). 03-18-113, § 388-452-0005, filed 9/2/03, effective 11/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-452-0005, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 01-14-060, § 388-452-0005, filed 6/29/01, effective 8/1/01; 00-22-087, § 388-452-0005, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 C.F.R. 435.907. 99-11-075, § 388-452-0005, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0420.]

WAC 388-452-0010 What does the family violence option mean for TANF/SFA recipients? The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), gave every state the option to have procedures in place to address issues of family violence for recipients receiving temporary assistance for needy families (TANF) or state family assistance (SFA).

(1) For TANF/SFA, it is family violence when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010(2) to one of the following:

(a) Physical acts that resulted in, or threatened to result in, physical injury;

(b) Sexual abuse;

(c) Sexual activity involving a dependent child;

(d) Being forced as the caretaker relative or a dependent child to engage in nonconsensual sexual acts or activities;

(e) Threats of or attempts at, physical sexual abuse;

(f) Mental abuse;

(g) Neglect or deprivation of medical care; or

(h) Stalking.

(2) Under the family violence option DSHS must:

(a) Screen and identify TANF/SFA recipients for a history of family violence;

(b) Notify TANF/SFA recipients about the family violence option both verbally and in writing;

(c) Maintain confidentiality as stated in RCW 74.04.060;

(d) Offer referral to social services or other resources for recipients who meet the criteria in subsection (1) of this section;

(e) Waive WorkFirst requirements in cases where the requirements would make it more difficult to escape family violence, unfairly penalize victims of family violence or place victims at further risk. Requirements to be waived may include:

(i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for instances where participation in regular work activities would place the recipient at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340. 06-03-048, § 388-452-0010, filed 1/10/06, effective 2/10/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-454 WAC
LIVING WITH A RELATIVE

WAC

WAC 388-454-0005 Can I get TANF or SFA benefits for the child living with me? (1) You can get temporary assistance for needy families (TANF) or state family assistance (SFA) for a child you live with if you are responsible for the care and control of the child and you are the child's:

(a) Parent or other relative as defined in WAC 388-454-0010;

(b) Court-ordered guardian or court-ordered custodian; or

(c) Other adult acting *in loco parentis* (in the place of a parent).

(2) If a child lives with more than one relative or parent because the relatives share custody of the child:

(a) We include the child in the assistance unit (AU) of the parent or relative that the child lives with for the majority of the time; or

(b) If relatives share physical custody of the child in equal amounts, we include the child in the AU of the parent or relative that first applies for assistance for the child.

(3) If you or the child in your AU is temporarily absent from the home according to WAC 388-454-0015 and 388-454-0020, you can still get TANF or SFA during the absence.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0005, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0006 The department makes background checks on adults who are acting in place of a parent without court-ordered custody. (1) We check your background when you ask for TANF or SFA benefits for a child who:

(a) Is not related to you; and

(b) Lives with you but you do not have a court order that gives you legal custody of the child.

(2) A child who is not related to you cannot receive TANF/SFA benefits while living with you until we have completed a background check and the results of the background check meet the criteria in subsection (3) through (5).

(3) A child who is not related to you cannot receive benefits while living with you if:

(a) You have been convicted of a crime listed in WAC 388-06-0170; or

(b) You have been convicted of a crime listed in WAC 388-06-0180 within the last five years.

(4) We review your background when you have been convicted of a crime listed in WAC 388-06-0180 more than five years ago to determine your character, suitability, and competence to receive benefits for a child not related to you. We consider the following factors:

(a) The amount of time that has passed since you were convicted;

(b) The seriousness of the crime that led to the conviction;

(c) The number and types of convictions in your background; and

(d) Your age at the time of the conviction.

(5) When you have a conviction for a crime other than those listed in WAC 388-06-0170 or 388-06-0180 we review your background as described in subsection (4) above.

(6) Expunged or sealed conviction records do not count against you.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0006, filed 12/7/01, effective 1/7/02.]

WAC 388-454-0010 Do I have to be related to a child in order to get TANF or SFA for the child? To get TANF or SFA, a child must live with a parent, other relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis*.

(1) We consider the following people as parents for TANF and SFA:

(a) The child's natural or adoptive parent; or

(b) A stepparent who is legally obligated to support the child.

(2) We consider a man as a child's natural father if the relationship is:

(a) Made under a judgment or order under RCW 26.26.130 that set the relationship between the parent and child; or

(b) Presumed under the Uniform Parentage Act (chapter 26.26 RCW).

(3) When a child lives with a relative, the relative must be one of the following relationships to the child in order for that child to be eligible for TANF or SFA:

(a) The following blood relatives (including relatives of half blood) or their spouses: Siblings, first cousins (including first cousins once removed), nephews and nieces, and persons of earlier generations (including aunts, uncles and grandparents) as shown by the prefixes of great, great-great, or great-great-great;

(b) A natural parent whose parental rights were terminated by a court order;

(c) A stepparent who no longer has to support the child because:

(i) The child's natural or adoptive parent died; or

(ii) Divorce or dissolution ended the marriage between the stepparent and the child's natural or adoptive parent.

(d) A step sibling even if the marriage between the step sibling's parent and the child's natural or adoptive parent ended by death, divorce or dissolution.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-012, § 388-454-0010, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0010, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0015 Temporary absence from the home. The temporary absence policy described in this WAC applies to the temporary assistance for needy families (TANF) and state family assistance (SFA) programs. In some situations, a child receiving TANF/SFA can continue to be eligible for TANF/SFA cash assistance when there is a temporary separation of the child and the child's caregiver. There must be a clear expectation the absence is temporary and the child is expected to be reunited with the family. Temporary absences can't exceed one hundred eighty days except as described in (1)(a).

(1) For recipients, temporary absences include, but are not limited to:

(a) A caregiver receiving care in a hospital, substance abuse treatment facility, or other medical institution. If the temporary care exceeds one hundred eighty days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(b) Out-of-home visits less than one hundred eighty days, when the caregiver is still responsible for the support and care of the child.

(c) A caregiver or child attending school or training as described in WAC 388-454-0020.

(d) Placement of a child in foster care or in the care of a relative or other adult, including when the child's primary caregiver is in a residential treatment facility. The division of children and family services (DCFS) must place the child and determine the child is expected to return to the primary caregiver within one hundred eighty days of the placement.

(2) For applicants, temporary absences include:

(a) When the child is placed in unlicensed foster care or in the care of a relative or other adult and DCFS expects the child will return to the home within one hundred eighty days of removal. Benefits can also be approved for an applicant if DCFS determines that the child will be in the care of the applying adult within thirty days of authorizing assistance even if the child has been out of the home for over one hundred eighty days.

(b) When the child is out of the home because of illness or hospitalization and the absence isn't expected to exceed one hundred eighty days.

(3) For situations described in (1)(d) and (2)(a) of this WAC, concurrent TANF or SFA cash assistance can be made for the child, only when DCFS places the child in the temporary care of an unlicensed-relative, other caregiver, or in foster care. DCFS must expect the child return to the home of the primary caregiver in one hundred eighty days.

(a) When the child goes into licensed foster care, the TANF/SFA grant to the parent continues.

(b) When the child goes into unlicensed care, whether with a relative or other caregiver, the TANF grant to the parent continues and the caregiver can also get a TANF grant.

(4) Situations that do not meet the criteria of a temporary absence include, but aren't limited to:

(a) The caregiver or child is incarcerated for any length of time.

(b) The child ran away and there is no clear expectation of when the child will be returning home.

(c) A caregiver or child is away attending school and doesn't meet the criteria outlined in WAC 388-454-0020.

(5) A caregiver must report within five days of learning that a child's absence is going to be greater than one hundred eighty days as required under WAC 388-418-0005 and 388-418-0007.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-14-105, § 388-454-0015, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0020 Temporary absence to attend school or training. A child or caretaker is temporarily absent from the home to attend school or training when:

(1) The child's caretaker is attending a department approved vocational training program; or

(2) The child attends school or training away from home, as long as:

(a) The child returns to the family home during a year's period, at least for summer vacation; and

(b) The absence is necessary because:

(i) Isolation of the child's home makes it necessary for the child to be away to attend school;

(ii) The child is enrolled in an Indian boarding school administered through the Bureau of Indian Affairs; or

(iii) Specialized education or training is not available in the child's home community and is recommended by local school authorities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0025 The department notifies a child's parent when we approve assistance and the child is living with someone other than their parent. (1) The department makes a reasonable effort to contact the parent with whom the child last lived when we find out that a child applying for assistance lives with someone other than the child's parent. We tell the parent:

(a) Within seven days of the date we approve assistance for the child;

(b) How to ask for family reconciliation services from the department; and

(c) How to request the child's address and location as allowed under WAC 388-428-0010.

(2) We do not notify the parent when there is evidence to support a claim that the parent has abused or neglected the child.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0025, filed 12/7/01, effective 1/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057 and 74.08.090. 98-16-044, § 388-454-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-455 WAC
LUMP SUM INCOME

WAC

WAC 388-455-0005 How do lump sum payments affect benefits? (1) A lump sum payment is money that someone receives but does not expect to receive on a continuing basis.

(2) For cash assistance and family medical programs, we count a lump sum payment:

(a) As a resource, under WAC 388-455-0010, if it was awarded for wrongful death, personal injury, damage, or loss of property.

(b) As income, under WAC 388-455-0015, if it was received for any other reason.

(3) For Basic Food, we count lump sum payments for a previous period as a resource under WAC 388-470-0055. We count any amount for current or future months as income to your assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-11-105, § 388-455-0005, filed 5/20/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0010 When and how does the department treat lump sum payments as a resource for cash assistance and family medical programs? (1) If you receive a lump sum payment, we count it as a resource if it was awarded for:

(a) Wrongful death;

(b) Personal injury;

(c) Damage; or

(d) Loss of property.

(2) If some of your lump sum payment is designated for medical bills or to repair or replace damaged property, we do not count the designated amount as a resource for sixty days starting the month after you received the payment. After the sixty day period, we count all of the lump sum payment that remains as a resource.

(3) For family medical programs, we do not count an increase in your resources if you are continuously eligible as described under WAC 388-470-0026 (1) and (2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-11-105, § 388-455-0010, filed 5/20/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0010, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0015 When and how does the department treat lump sum payments as income for cash assistance and family medical programs. This section applies to cash and family medical programs.

(1) If you receive a lump sum payment that is not awarded for wrongful death, personal injury, damage, or loss of property, we count this payment as income to your assistance unit. We budget this income according to effective date rules under WAC 388-418-0020.

(2) For cash assistance, if you cannot access some or all of your lump sum payment for reasons beyond your control, we will adjust the amount we count as income to your assistance unit as described under WAC 388-450-0005.

(3) To decide the amount of your lump sum we count as income, we take the following steps:

(a) First, we subtract the value of your current resources from the resource limit under WAC 388-470-0005;

(b) Then, we subtract the difference in (3)(a) from the total amount of the lump sum; and

(c) The amount left over is what we count as income, as specified in WAC 388-450-0025 and 388-450-0030.

(4) When the countable amount of the lump sum payment is:

(a) Less than your payment standard plus additional requirements, we count it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We count the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We count the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we count the payment as income for those months.

(5) If you receive a one-time lump sum payment, and you are ineligible or disqualified from receiving cash benefits:

(a) We allocate the payment to meet your needs as described under WAC 388-450-0105; and

(b) Count the remainder as a lump sum payment available to eligible members of your assistance unit according to the rules of this section.

(6) For family medical programs:

(a) We count lump sum payments as income in the month you receive the payment.

(b) If you cannot access some or all of your lump sum payment for reasons beyond your control, will adjust the amount we count as income to your assistance unit as described under WAC 388-450-0005.

(c) We count any money that remains on the first of the next month as a resource except for recipients as described in WAC 388-470-0026 (1) and (2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-11-105, § 388-455-0015, filed 5/20/08, effective 7/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

Chapter 388-458 WAC
NOTICES TO CLIENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-458-0001 How the department requests information or action needed when a client applies for assistance or reports a change. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0001, filed 11/10/99, effective 1/1/00.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-458-0005 Adequate notice of denial or withdrawal. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0005, filed 7/31/98, effective 9/1/98.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-458-0010 Adequate notice of adverse action to recipients. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0010, 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, § 388-458-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2520.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-458-0015 Translation of written communications with limited English proficient clients. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0015, filed 7/31/98, effective 9/1/98.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-458-0002 The department of social and health services (DSHS) sends you letters to tell you about your case. (1) When you apply for or get benefits, we send you letters to tell you about your case.

(2) If you speak another language and cannot read English, we send letters to you in your primary language.

(3) There are seven basic types of letters that we send to you:

(a) Withdrawals;

(b) Denials;

(c) Approvals;

(d) Requests;

(e) Changes;

(f) Terminations; and

(g) Other.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0002, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0006 DSHS sends you a letter when you withdraw your application. (1) We send you a withdrawal letter when you tell us that you no longer want to apply for benefits.

(2) On this letter, we tell you:

(a) The date we stopped processing your application; and

(b) Your right to have your case reviewed or ask for a fair hearing.

(3) We send this letter to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0006, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0011 DSHS sends you a denial letter when you can't get benefits. (1) When we finish processing your application, we send you a denial letter if you cannot get benefits.

(2) On this letter, we tell you:

(a) Why you cannot get benefits;

(b) The rules that support our decision;

(c) The date we stopped processing your application; and

(d) Your right to have your case reviewed or ask for a fair hearing.

(3) If we are denying your application because you did not give us some information that we needed and we can't figure out if you are eligible without it, we also tell you on the letter:

(a) What information you didn't give to us;

(b) The date we asked for the information and the date it was due;

(c) That we cannot figure out if you can get benefits without this information; and

(d) That we will review your eligibility if:

(i) For cash and medical, you give us the information within thirty days of the date of the notice;

(ii) For food assistance, you give us the information within sixty days of the date you applied; and

(iii) Your circumstances have not changed.

(4) We send denial letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0011, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0016 DSHS sends you an approval letter when you can get benefits. (1) When we finish processing your application, we send you an approval letter if you can get benefits.

(2) On this letter, we tell you:

(a) What kind of benefits you get;

(b) If you applied for cash or food assistance, the amount of benefits you get;

(c) If you applied for medical, what type of medical;

(d) How long you will get the benefits; and

(e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send approval letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0016, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0020 You get a request letter when we need more information. (1) We send a request letter to you when we need some information from you or you have to do something in order to get benefits.

(2) On the letter, we tell you:

(a) What is needed;

(b) The date it is due; and

(c) What will happen to your benefits if you don't do what we ask.

(3) You get at least ten days to give us the information or do the activity. You can ask for more time if you need it.

(4) If the tenth day is on a weekend or holiday, you have until the next business day to do what we need.

(5) If we don't get what we need by the due date, we may deny, reduce, or stop your benefits. We will send you another letter if this happens.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0020, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0025 We send you a change letter if the amount of benefits you are getting is changing. (1) We send you a change letter if the amount of benefits you are getting is changing.

(2) On the letter, we tell you:

(a) What your benefits are changing to;

(b) When the change is going to happen;

(c) The reason for the change;

(d) The rules that support our decision; and

(e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send the letter to you before the change happens. If your benefits are going down, we give you at least ten days notice unless:

(a) You ask us to reduce your benefits;

(b) We have to change benefits for a lot of people at once because of a law change;

(c) For cash and food assistance:

(i) We told you on your approval letter that your benefits might change every month because you have fluctuating income; or

(ii) We already told you that the supplement would end.

(d) For cash assistance, we told you that the AREN payment described in WAC 388-436-0002 was for one month only.

(4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.

(5) If we don't have to give you ten days notice, we send the letter to you:

(a) For cash and medical, by the date of the action.

(b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0025, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0030 We send you a termination letter when your benefits stop. (1) We send you a termination letter when your benefits stop.

(2) On the letter, we tell you:

(a) When your benefits are going to end;

(b) The reason they are ending;

(c) The rules that support our decision; and

(d) Your right to have your case reviewed or ask for a fair hearing.

(3) We tell you at least ten days before your benefits end unless;

(a) You asked us to stop your benefits;

(b) We have proof that everyone in your assistance unit has moved to another state or will move to another state before the next benefits are issued;

(c) We have proof that everyone in your assistance unit has died;

(d) We have to change benefits for a lot of people at once because of a law change;

(e) We got returned mail from the post office that says you have moved and we do not have a forwarding address; or

(f) For food assistance, your certification period is ending.

(4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.

(5) If we don't have to give you ten days notice, we send the letter to you:

(a) For cash and medical, by the date of the action.

(b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090, 74.04.057, and 74.04.510. 02-14-086, § 388-458-0030, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0030, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0035 Why do you give me ten days notice before you reduce or stop my benefits? (1) We give you ten days notice before reducing or stopping your benefits so that you have some time to either:

(a) Get the needed information to us; or

(b) Prepare yourself and your family for the change.

(2) You can also use this time to request a fair hearing.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0035, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0040 What happens if I ask for a fair hearing before the change happens? (1) If you ask for a fair hearing within the ten-day notice period, you may keep getting the amount of benefits you were getting before the change. This is called continued benefits.

(2) If the tenth day falls on a weekend or holiday, you have until the next business day to ask for a fair hearing and still be able to get continued benefits.

(3) If the tenth day happens before the end of the month, you have until the end of the month to ask for a fair hearing and still be able to get continued benefits.

(4) For food assistance, you cannot get continued benefits if your certification period is ending.

(5) If you get continued benefits, you keep getting them through the end of the month the fair hearing decision is mailed unless:

(a) You:

(i) Tell us in writing that you do not want continued benefits;

(ii) Withdraw your fair hearing request in writing; or

(iii) Do not follow through with the fair hearing process.

(b) An administrative law judge (ALJ) tells us in writing to stop your continued benefits before the hearing.

(c) For food assistance, your certification period ends.

(6) After the fair hearing, you have to pay back continued benefits you get, as described in chapter 388-410 WAC, if the ALJ agrees with our decision.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0040, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0045 Will I get other kinds of letters? Yes. We also send you letters in special circumstances. These letters are specific to your situation. Here are some examples:

(1) Appointment letters;

(2) Overpayment letters; and

(3) Fair Hearing letters.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0045, filed 7/25/01, effective 9/1/01.]

Chapter 388-460 WAC

PAYEES ON BENEFIT ISSUANCES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-460-0045 Are clients in WorkFirst sanction status assigned protective payees? [Statutory Authority: RCW 74.08A.010 (4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0045, filed 6/28/02, effective 7/1/02.] Repealed by 06-10-034, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW.

WAC 388-460-0001 Who may be issued cash, child care, medical and Basic Food benefits? (1) Cash and child care assistance may be issued in the name of the following persons:

(a) A client who is the recipient of the benefits;

(b) An ineligible parent or other relative getting benefits on behalf of an eligible child;

(c) A person, facility, organization, institution or agency acting as a protective payee or representative payee for a client;

(d) A guardian or agent acting on behalf of a client; or

(e) A vendor of goods or services supplied to an eligible client.

(2) When medical coverage accompanies cash assistance, the medical identification (MAID) card for the assistance unit members is issued in the name of the person listed as payee for the cash benefit.

(3) For other medical assistance units, the MAID card is issued to the person named as the head of the assistance unit.

(4) Basic Food benefits are issued to the person named as the head of the assistance unit for Basic Food.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-460-0001, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0001, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0005 Can I choose someone to apply for Basic Food for my assistance unit? Your Basic Food assistance unit (AU) can choose an adult who is not a member of the AU to act on their behalf. This is called an authorized representative.

(1) A responsible member of the AU can name, in writing, an authorized representative. A responsible member of the AU is either:

(a) The applicant;

(b) The applicant's spouse;

(c) Another member of the AU the applicant states is able to conduct business on behalf of all members in the AU.

(2) The AU's authorized representative has the authority to apply for Basic Food on the AU's behalf.

(3) If you receive Basic Food benefits in a qualified drug and alcohol treatment facility under WAC 388-408-0040, you **must** have an employee of the facility as your authorized representative for Basic Food.

(4) If the authorized representative provides information to the department that causes an AU to have an overpayment, the AU members are liable for the overpayment.

(5) An authorized representative may act on behalf of more than one Basic Food AU **only** if the community services office administrator approves.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-460-0005, filed 10/28/03, effective 12/1/03; 03-03-072, § 388-460-0005, filed 1/15/03, effective 3/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0010 Do I have an authorized representative for Basic Food if I live in a treatment center or group home? (1) If you live in a qualified DDD group home under WAC 388-408-0040, you may choose to apply for Basic Food benefits:

(a) On your own behalf;

(b) Through an authorized representative of your choice; or

(c) Through the DDD group home acting as your authorized representative.

(2) If you live in a qualified drug and alcohol treatment center under WAC 388-408-0040, you **must** have an employee of the facility as your authorized representative for Basic Food.

(3) The person acting as authorized representative for residents in a qualified drug and alcohol treatment facility or qualified DDD group home must:

(a) Be aware of the resident's circumstances;

(b) Notify the department of any changes in income, resources or circumstances within ten days of the change;

(c) Use the resident's Basic Food benefits for meals served to the resident; and

(d) Keep enough benefits in the facility's account to transfer one-half of a client's monthly allotment to the client's own account. If the client leaves the facility on or before the fifteenth of the month, the facility must return one half of the client's Basic Food allotment for that month.

(4) When a facility assigns an employee as the authorized representative for residents, the facility accepts responsibility for:

(a) Any misrepresentation or intentional program violation; and

(b) Liability for Basic Food benefits held at the facility on behalf of the resident.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-460-0010, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-460-0010, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0015 Who will the department not allow as an authorized representative for Basic Food? (1) If you are acting as an authorized representative for Basic Food, we disqualify you from being an authorized representative for one year is we determine that you:

(a) Knowingly provided false information to the department;

(b) Misrepresented the circumstances of the Basic Food assistance unit (AU); or

(c) Misused the Basic Food benefits.

(2) If we disqualify you from being an authorized representative for Basic Food, we notify you and the head of the Basic Food AU thirty days before your disqualification starts.

(3) If you are a department employee, a retailer authorized to receive Basic Food benefits, or are disqualified from receiving Basic Food because of an intentional program violation under WAC 38-446-0015, you generally cannot be an authorized representative. If you are in any of these three categories and want to be an authorized representative for Basic Food:

(a) The AU must have no one else available to be an authorized representative; and

(b) You must have written approval from the community services office administrator to be the AU's authorized representative.

(4) A public or private nonprofit organization providing meals for homeless persons may not be an authorized representative under any conditions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-460-0015, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0020 Who is a protective payee? (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs - housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;

(b) Mismanagement of money (TANF/SFA, GA, or WCCC) per WAC 388-460-0035; or

(c) Pregnant or parenting minors per WAC 388-460-0040.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-460-0020, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.-090, 74.04.050. 02-14-083, § 388-460-0020, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0025 Who can be a protective payee? (1) Clients may ask for a particular protective payee, but the department makes the final choice.

(2) Protective payees must contract with the department, except for employees of the department who are assigned this function as part of their job duties.

(3) The contracted protective payee and their staff must pass a criminal background check according to the criteria in WAC 388-06-0170, 388-06-0180 and 388-06-0190.

(4) A departmental employee acting as a protective payee must pass a criminal background check and cannot:

(a) Have the client in their caseload,

(b) Have the client in the caseloads of other employees under their supervision,

(c) Be responsible for determining or issuing benefits for the client,

(d) Be the office administrator, or

(e) Be a special investigator.

(5) For TANF/SFA, a department employee cannot act as a protective payee when the department has legal custody or responsibility for placement and care of the child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0025, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0030 When is an emergency or temporary protective payee (TANF/SFA) used? An emergency or temporary protective payee is assigned when a caretaker relative or adult acting in loco parentis per WAC 388-454-0005 is not available to take care of and supervise a child due to an emergency.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0030, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0035 When is a protective payee assigned for mismanagement of funds? (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based on law or with proof the client is unable to manage their cash benefits. The proof must be current and show how this threatens the well being of a child or client on TANF/SFA, GA or WCCC. Examples of proof are:

(a) Department employees or others observe that the client or client's children are hungry, ill, or not adequately clothed;

(b) Repeated requests from the client for extra money for basic essentials such as food, utilities, clothing, and housing;

(c) A series of evictions or utility shut off notices within the last twelve months;

(d) Medical or psychological evaluations showing an inability to handle money;

(e) Persons having had an ADATSA assessment and who are participating in ADATSA-funded chemical dependency treatment;

(f) Not paying an in home child care provider for services when payment has been issued to the client by the department for that purpose;

(g) A complaint from businesses showing a pattern of failure to pay bills or rent;

(h) Using public assistance electronic benefits transfer (EBT) card or cash obtained through EBT to purchase or pay for lottery tickets, pari-mutuel wagering, or any of the activities authorized under chapter 9.46 RCW.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid through a protective payee or directly to a vendor.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0035, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0040 When is a protective payee assigned to TANF/SFA pregnant or parenting minors? Pregnant or parenting minors who are not emancipated under court order must be assigned to protective payees if the clients are:

(1) Head of a household;

(2) Under age eighteen;

(3) Unmarried; and

(4) Pregnant or have a dependent child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0040, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0050 When is a client transferred from a protective payee to guardianship? (1) In emergency cases where a person is physically or mentally unable to manage their own funds, the client is referred to other divisions of the department for full care, including guardianship.

(2) In cases where a child is eligible for TANF/SFA and the caretaker relative does not use the benefits for adequate care of the child, the case can be referred to the attorney general to establish a limited guardianship.

(3) Guardianships are used only if it appears there is a need for services that are expected to last longer than two years.

(4) These guardianships are limited to management of DSHS benefits.

(5) The protective payee plan is changed if a guardian is appointed. The guardian is designated as the payee.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0050, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0055 What are the protective payee's responsibilities? The protective payee's responsibilities are to:

(1) Manage client cash and child care assistance benefits to pay bills for basic needs, such as housing and utilities, or as directed in the protective payee plans;

(2) Provide money management for client if this item is included in the protective payee plans; and

(3) Provide reports to the department on client progress.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and chapter 74.08A RCW. 06-10-034, § 388-460-0055, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0055, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0060 When are protective payee plans done? A protective payee plan may be developed when a case is assigned to a protective payee.

(1) A copy of the plan is provided to the protective payee and the client.

(2) All cases must be reviewed:

(a) After an initial three-month period; and

(b) At least every six months beyond the initial period for on going cases.

(3) Reviews include evaluation of:

(a) The need for the client to continue in protective payee status; or

(b) The need to change the plan; or

(c) The client's potential to assume control of their funds (or be removed from protective payee status); and

(d) Protective payee performance.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0060, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0065 When is the protective payee status ended and how is a protective payee changed? A client may be removed from a protective payee status when a:

(1) Protective payee requests the client be reassigned;

(2) The department assigns a different protective payee; or

(3) Protective payee is no longer required.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0065, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0070 What are your fair hearing rights regarding protective payment? You have the right for a fair hearing if you disagree with the department's decision to:

(1) Assign payment of benefits through a protective payee,

(2) Continue the assignment,

(3) Change the protective payee selected for you, or

(4) Change the contents of your protective payee plan.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-14-083, § 388-460-0070, filed 6/28/02, effective 7/1/02.]

Chapter 388-462 WAC
PREGNANCY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-462-0005 Pregnancy requirement for GA-S. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-045, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.005, 74.04.-050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-462-0010 Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women. (1) If you are already receiving TANF or SFA benefits, your pregnancy will not change your eligibility or benefit level.

(2) If you are not currently receiving TANF or SFA benefits, you may be eligible for these benefits if your pregnancy and expected date of delivery has been verified by a licensed medical practitioner.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0011 Post adoption cash benefit. (1) Under RCW 74.04.005 (6)(g) recipients of TANF or SFA who lose their eligibility solely because of the birth and relinquishment of the qualifying child may receive general assistance through the end of the month in which the period of six weeks following the birth of the child falls.

(2) The department will consider income and resources when determining eligibility and benefit amount for post adoption cash benefit in the same manner as TANF. Refer to chapters 388-450, 388-470, and 388-488 WAC.

(3) To receive the post adoption cash benefit, a client must have been receiving TANF or SFA in Washington state.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0011, filed 6/30/99, effective 8/1/99.]

WAC 388-462-0015 Medical eligibility for pregnant women. Eligibility requirements for pregnancy medical are described below.

(1) A pregnant woman is eligible for categorically needy (CN) scope of care if she meets the following requirements:

(a) Citizenship or immigration status (chapter 388-424 WAC); and

(b) Social Security account number (chapter 388-474 WAC); and

(c) Is a Washington state resident (chapter 388-468 WAC); and

(d) Has countable income as described in WAC 388-478-0075.

(2) A pregnant woman is considered for medically needy (MN) scope of care if she meets the requirements in subsection (1)(a) through (c) of this section and:

(a) Has countable income that exceeds the standard in subsection (1)(d) of this section; and

(b) Has countable resources that do not exceed the standard in WAC 388-478-0070.

(3) A pregnant woman may be eligible for noncitizen pregnancy medical if she is not eligible for medical described in subsections (1) and (2) of this section due to citizenship, immigrant status, or social security number requirements.

(4) A pregnant woman meeting the eligibility criteria in subsection (3) is eligible for:

(a) CN scope of care when the countable income is at or below the income standard described in subsection (1)(d); or

(b) MN scope of care when:

(i) The countable income exceeds the standard in subsection (1)(d); and

(ii) The resources do not exceed the standard described in WAC 388-478-0070.

(5) Consider as income to the pregnant woman the amount that is actually contributed to her by the father of her unborn child when the pregnant woman is not married to the father.

(6) The assignment of child support and medical support rights as described in chapter 388-422 WAC do not apply to pregnant women.

(7) A woman who was eligible for and received medical coverage on the last day of pregnancy is eligible for extended medical benefits for postpartum care for a minimum of sixty days from the end of her pregnancy. This extension continues through the end of the month in which the sixtieth day falls.

(8) A woman who was eligible for medical coverage on the last day of pregnancy is eligible for family planning services for twelve months from the end of the pregnancy even when eligibility for pregnancy was determined after the pregnancy ended.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-032, § 388-462-0015, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.-415. 02-17-030, § 388-462-0015, 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, § 388-462-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0820, 388-508-0830, 388-522-2230 and 388-508-0835.]

WAC 388-462-0020 Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility. (1) Effective July 1, 2001, a woman is eligible for categorically needy (CN) coverage under the BCCTP only when she:

(a) Has been screened for breast or cervical cancer under the center for disease control (CDC) breast and cervical cancer early detection program (BCCEDP);

(b) Is found to require treatment for either breast or cervical cancer or for a related precancerous condition;

(c) Is under sixty-five years of age;

(d) Is not eligible for another CN medicaid program;

(e) Is uninsured or does not otherwise have creditable coverage;

(f) Meets residency requirements as described in WAC 388-468-0005;

(g) Meets Social Security number requirements as described in WAC 388-476-0005; and

(h) Meets the requirements for citizenship or U.S. national status as defined in WAC 388-424-0001 or "qualified alien" status as described in WAC 388-424-0006 (1) or (4).

(2) The certification periods described in WAC 388-416-0015 (1), (4), and (6) apply to the BCCTP. Eligibility for medicaid continues throughout the course of treatment as certified by the CDC-BCCEDP.

(3) Income and asset limits are set by the CDC-BCCEDP.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-462-0020, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 74.09.510, and Public Law 106-354. 02-01-134, § 388-462-0020, filed 12/19/01, effective 1/19/02.]

Chapter 388-464 WAC
QUALITY ASSURANCE

WAC

WAC 388-464-0001 Requirement to cooperate with quality assurance. (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or federal food stamp benefits, the following clients are required to cooperate in the quality assurance review process:

(a) All adult recipients or payees in a TANF or SFA assistance unit; or

(b) All household members in a food assistance unit.

(2) Assistance units become ineligible for benefits upon a determination of noncooperation by quality assurance and remain ineligible until the client meets quality assurance requirements or:

(a) For TANF/SFA clients, one hundred twenty days from the end of the annual quality assurance review period; or

(b) For food assistance household members, ninety-five days from the end of the annual quality assurance review period.

(3) The quality assurance review period covers the federal fiscal year which runs from October 1st of one calendar year through September 30th of the following year.

(4) Individuals reapplying for TANF, SFA, or federal food stamps after the sanction period has ended must provide verification of all eligibility requirements. However, individuals meeting expedited service criteria only need to provide expedited service verification requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-464-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-466 WAC
REFUGEE PROGRAM

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-466-0010 Treatment of income and resources for refugee assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0010, filed 7/31/98, effective 9/1/98.] Repealed by 02-04-057, filed 1/30/02, effective 2/1/02. Statutory Authority: RCW 74.08.090, 74.08A.320.

388-466-0015 Work and training requirements for refugee cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0015, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

388-466-0020 Exemptions to work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0020, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

388-466-0025 Penalties for not complying with work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0025, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-466-0005 Immigration status requirement for refugee assistance. (1) You may be eligible for refugee cash assistance (RCA) and refugee medical assistance (RMA), if you can provide documentation issued by the U.S. Citizenship and Immigration Services (USCIS), that you are:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);

(b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;

(c) Granted conditional entry under section 203 (a)(7) of the INA;

(d) Granted asylum under section 208 of the INA;

(e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA;

(g) Certified as a victim of human trafficking by the federal office of refugee resettlement (ORR);

(h) An eligible family member of a victim of human trafficking certified by ORR who has a T-2, T-3, T-4, or T-5 Visa;

(i) Admitted as Special Immigrant from Iraq or Afghanistan under section 101 (a)(27) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsections (1)(a) through (g) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0005, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0120 Refugee cash assistance (RCA). (1) **Who can apply for refugee cash assistance (RCA)?**

Anyone can apply to the department of social and health services (DSHS) for refugee cash assistance and have their eligibility determined within thirty days.

(2) **How do I know if I qualify for RCA?**

You may be eligible for RCA if you meet all of the following conditions:

(a) You have resided in the United States for less than eight months;

(b) You meet the immigration status requirements of WAC 388-466-0005;

(c) You meet the income and resource requirements under chapters 388-450 and 388-470 WAC;

(d) You meet the work and training requirements of WAC 388-466-0150; and

(e) You provide the name of the voluntary agency (VOLAG) which helped bring you to this country.

(3) **What are the other reasons for not being eligible for RCA?**

You may not get RCA if you:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income (SSI); or

(b) Have been denied TANF due to your refusal to meet TANF eligibility requirements; or

(c) Are employable and have voluntarily quit or refused to accept a bona fide offer of employment within thirty consecutive days immediately prior to your application for RCA; or

(d) Are a full-time student in a college or university.

(4) **If I am an asylee, what date will be used as an entry date?**

If you are an asylee, your entry date will be the date that your asylum status is granted. For example: You entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and were granted asylum on September 1, 2000. Your entry date is September 1, 2000. On September 1, 2000, you may be eligible for refugee cash assistance.

(5) **If I am a victim of human trafficking, what kind of documentation do I need to provide to be eligible for RCA?**

You are eligible for RCA to the same extent as a refugee if you are:

(a) An adult victim, eighteen years of age or older, you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS), and you meet eligibility requirements in subsections (2)(c) and (d) of this section. You do not have to provide any other documentation of your immigration status. Your entry date will be the date on your certification letter;

(b) A child victim under the age of eighteen, in which case you do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirement;

(c) A family member of a certified victim of human trafficking, you have a T-2, T-3, T-4, or T-5 Visa (Derivative T-Visas), and you meet the eligibility requirements in subsections (2)(c) and (d) of this section.

(6) **Does getting a one time cash grant from a voluntary agency (VOLAG) affect my eligibility for RCA?**

No. In determining your eligibility for RCA DSHS does not count a onetime resettlement cash grant provided to you by your VOLAG.

(7) **What is the effective date of my eligibility for RCA?**

The date DSHS has sufficient information to make eligibility decision is the date your RCA begins.

(8) **When does my RCA end?**

(a) Your RCA ends on the last day of the eighth month starting with the month of your arrival to the United States. Count the eight months from the first day of the month of your entry into the United States. For example, if you entered the United States on May 28, 2000, May is your first month and December 2000 is your last month of RCA.

(b) If you are from Afghanistan and were granted special immigrant status under section 101 (a)(27) of the Immigration and Nationality Act (INA), your RCA ends on the last day of the sixth month starting from the month of your arrival to the United States or from the month you received special immigrant status if this occurred after your entry.

(c) If you get a job, your income will affect your RCA based on the TANF rules (chapter 388-450 WAC). If you earn more than is allowed by WAC 388-478-0035, you are no longer eligible for RCA. Your medical coverage may continue for up to eight months from your month of arrival in the United States (WAC 388-466-0130).

(9) **Are there other reasons why RCA may end?**

Your RCA also ends if:

(a) You move out of Washington state;

(b) Your unearned income and/or resources go over the maximum limit (WAC 388-466-0140); or

(c) You, without good cause, refuse to meet refugee employment and training requirements (WAC 388-466-0150).

(10) **Will my spouse be eligible for RCA, if he/she arrives in the U.S. after me?**

When your spouse arrives in the United States, DSHS determines his/her eligibility for RCA and/or other income assistance programs.

(a) Your spouse may be eligible for up to eight months of RCA based on his/her date of arrival into the United States. Spouses from Afghanistan who have been granted special immigrant status under section 101 (a)(27) of the INA, are eligible for RCA for up to six months from the date of their entry into the United States or from the month they received special immigrant status if this occurred after their U.S. entry.

(b) If you live together you and your spouse are part of the same assistance unit and your spouse's eligibility for RCA

is determined based on your and your spouse's combined income and resources (WAC 388-466-0140).

(11) **Can I get additional money in an emergency?**

If you have an emergency and need a cash payment to get or keep your housing or utilities, you may apply for the DSHS program called additional requirements for emergent needs (AREN). To receive AREN, you must meet the requirements in WAC 388-436-0002.

(12) **What can I do if I disagree with a decision or action that has been taken by DSHS on my case?**

If you disagree with a decision or action taken on your case by the department, you have the right to request a review of your case or a fair hearing (WAC 388-02-0090). Your request must be made within ninety days of the decision or action.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0120, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.08.090, 74.08A.320. 02-04-057, § 388-466-0120, filed 1/30/02, effective 2/1/02.]

WAC 388-466-0130 Refugee medical assistance (RMA). (1) **Who can apply for refugee medical assistance?**

Anyone can apply for refugee medical assistance (RMA) and have eligibility determined by the department of social and health services (DSHS).

(2) **Who is eligible for refugee medical assistance?**

(a) You are eligible for RMA if you meet all of the following conditions:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Income and resource requirements of WAC 388-466-0140;

(iii) Monthly income standards up to two hundred percent of the federal poverty level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110); and

(iv) Provide the name of the voluntary agency (VOLAG) which helped bring you to this country, so that DSHS can promptly notify the agency (or sponsor) about your application for RMA.

(b) You are eligible for RMA if you:

(i) Receive refugee cash assistance (RCA) and are not eligible for medicaid or children's healthcare programs as described in WAC 388-505-0210; or

(ii) Choose not to apply for or receive RCA and are not eligible for medicaid or children's healthcare programs as described in WAC 388-505-0210, but still meet RMA eligibility requirements.

(3) **Who is not eligible for refugee medical assistance?**

You are not eligible to receive RMA if you are:

(a) Already eligible for medicaid or children's healthcare programs as described in WAC 388-505-0210;

(b) A full-time student in an institution of higher education unless the educational activity is part of a department-approved individual responsibility plan (IRP);

(c) A nonrefugee spouse of a refugee.

(4) **If I have already received a cash assistance grant from voluntary agency (VOLAG), will it affect my eligibility for RMA?**

No. A cash assistance payment provided to you by your VOLAG is not counted in determining eligibility for RMA.

(5) **If I get a job after I have applied but before I have been approved for RMA, will my new income be counted in determining my eligibility?**

No. Your RMA eligibility is determined on the basis of your income and resources on the date of the application.

(6) **Will my sponsor's income and resources be considered in determining my eligibility for RMA?**

Your sponsor's income and resources are not considered in determining your eligibility for RMA unless your sponsor is a member of your assistance unit.

(7) **How do I find out if I am eligible for RMA?**

DSHS will send you a letter in both English and your primary language informing you about your eligibility. DSHS will also let you know in writing every time there are any changes or actions taken on your case.

(8) **Will RMA cover my medical expenses that occurred after I arrived in the U.S. but before I applied for RMA?**

You may be eligible for RMA coverage of your medical expenses for three months prior to the first day of the month of your application. Eligibility determination will be made according to medicaid rules.

(9) **If I am a victim of human trafficking, what kind of documentation do I need to provide to be eligible for RMA?**

You are eligible for RMA to the same extent as a refugee, if you are:

(a) An adult victim, eighteen years of age or older, and you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS). You also have to meet eligibility requirements in subsections (2)(a) and (b) of this section. You do not have to provide any other documentation of your immigration status. Your entry date will be the date on your certification letter.

(b) A child victim under the age of eighteen, in which case you do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirements.

(c) A family member of a certified victim of human trafficking, you have a T-2, T-3, T-4, or T-5 Visa (Derivative T-Visas), and you meet eligibility requirements in subsections (2)(a) and (b) of this section.

(10) **If I am an asylee, what date will be used as an entry date?**

If you are an asylee, your entry date will be the date that your asylum status is granted. For example, if you entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and granted asylum on September 1, 2000, your date of entry is September 1, 2000. On September 1, 2000 you may be eligible for refugee medical assistance.

(11) **When does my RMA end?**

(a) Your refugee medical assistance will end on the last day of the eighth month from the month of your entry into the United States. Start counting the eight months with the first day of the month of your entry into the U.S. For example, if

you entered the U.S. on May 28, 2000, your last month is December 2000.

(b) If you are from Afghanistan and were granted Special Immigrant status under section 101 (a)(27) of the Immigration and Nationality Act (INA), your RMA ends on the last day of the sixth month starting with the month of your arrival to the United States or from the month you received Special Immigrant status if this occurred after your U.S. entry.

(12) **What happens if my earned income goes above the income standards?**

(a) If you are getting RMA, your medical eligibility will not be affected by the amount of your earnings;

(b) If you were getting medicaid and it was terminated because of your earnings, we will transfer you to RMA for the rest of your RMA eligibility period. You will not need to apply.

(13) **Will my spouse also be eligible for RMA, if he/she arrives into the U.S. after me?**

When your spouse arrives in the U.S., we will determine his/her eligibility for medicaid and other medical programs.

(a) Your spouse may be eligible for RMA; if so, he/she would have a maximum of eight months of RMA starting on the first day of the month of his/her arrival.

(b) Spouses from Afghanistan who have been granted special immigrant status under section 101 (a)(27) of the Immigration and Nationality Act (INA), are eligible for RMA for a maximum of six months from the date of entry into the United States or from the month they received special immigrant status if this occurred after their U.S. entry.

(14) **What do I do if I disagree with a decision or action that has been taken by DSHS on my case?**

If you disagree with the decision or action taken on your case by department you have the right to request a review of your case or request a fair hearing (see WAC 388-02-0090). Your request must be made within ninety days of the decision or action).

(15) **What happens to my medical coverage after my eligibility period is over?**

We will determine your eligibility for other medical programs. You may have to complete an application for another program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0130, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-466-0130, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.08A.320. 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

WAC 388-466-0140 Income and resources for refugee assistance eligibility. (1) **How does DSHS count my income and resources when determining my eligibility for refugee cash assistance?**

We determine your eligibility for RCA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except we do not count a onetime resettlement cash payment provided to you by your voluntary agency (VOLAG).

(2) **How does DSHS count my income and resources when determining my eligibility for refugee medical assistance?**

We determine your eligibility for RMA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except as it stated below:

(a) Your monthly income can be up to two hundred percent of the federal poverty level (FPL);

(b) A onetime resettlement cash payment provided to you by your VOLAG is not counted in determining your eligibility for RMA;

(c) Your RMA eligibility is determined on the basis of your income and resources on the date of your application (WAC 388-466-0130).

[Statutory Authority: RCW 74.08.090, 74.08A.320. 02-04-057, § 388-466-0140, filed 1/30/02, effective 2/1/02.]

WAC 388-466-0150 Refugee employment and training services. (1) **What are refugee employment and training services?**

Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.

(2) **Am I required to participate in refugee employment and training services?**

If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.

(3) **How do I know if I am exempt from mandatory employment and training requirements?**

(a) You may be exempt from participation in employment and training requirements if:

(i) You are needed in the home to personally provide care for your child under three months of age (see WAC 388-310-0300);

(ii) You are sixty years of age or older.

(b) You can not be exempt from work and training requirements solely because of an inability to communicate in English.

(4) **If I am required to participate, what do I have to do?**

You are required to:

(a) Register with your employment service provider;

(b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.

(5) **What happens if I do not follow these requirements?**

If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:

(a) If you are applying for refugee cash and medical assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or

(b) If you are already receiving refugee cash and medical assistance, your cash benefits will be subject to financial penalties.

(c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.

(6) **What are the penalties to my grant?**

The penalties to your grant are:

(a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.

(b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.

(7) **How can I avoid the penalties?**

You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.

(8) **What is considered a good reason for not being able to follow the requirements?**

You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC 388-310-1600(3) for examples.

[Statutory Authority: RCW 74.08.090. 00-22-085, § 388-466-0150, filed 10/31/00, effective 12/1/00.]

Chapter 388-468 WAC
RESIDENCY

WAC

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) With the exception of subsection (5) of this section, a client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.

(6) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(7) A former resident of the state can apply for the GA-U program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (7)(a)(i)(ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(8) Residency is not a requirement for detoxification services.

(9) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (10) of this section.

(10) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(11) For purposes of medical programs, a client's residence is the state:

(a) Paying a state Supplemental Security Income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(12) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

[Statutory Authority: RCW 74.08.090. 03-20-060, § 388-468-0005, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-468-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-470 WAC
RESOURCES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-470-0010 How to determine who owns a resource. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0010, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0015 Availability of resources. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-507-0730.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0020 Excluded resources. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0025 Excluded resources for cash assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0025, 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, § 388-470-0025, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0030 Excluding a home as a resource. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0030, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0035 Excluded resources for food assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0035, 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, § 388-470-0035, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0040 Additional excluded resources for SSI-related medical assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-511-1160.] Repealed by 04-09-003, filed 4/7/04, effective 6/1/04. Statutory Authority: RCW 74.04.050, 74.08.090. Later promulgation, see chapter 388-475 WAC.

388-470-0050 Resources that count. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0050, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0065 Individual development accounts for TANF recipients. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0065, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-470-0080 Compensatory award or related settlement lump sum payments. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-470-0005 How do resources affect my eligibility for cash assistance, medical assistance, and Basic Food? (1) The following definitions apply to this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person applying for or getting benefits from the department.

(c) **"Fair market value (FMV)"** means the price at which you could reasonably sell the resource.

(d) **"Equity value"** means the FMV minus any amount you owe on the resource.

(e) **"Community property"** means a resource in the name of the husband, wife, or both.

(f) **"Separate property"** means a resource of a married person that one of the spouses:

(i) Had possession of and paid for before they were married;

(ii) Acquired and paid for entirely out of income from separate property; or

(iii) Received as a gift or inheritance.

(2) We count a resource to decide if your assistance unit (AU) is eligible for cash assistance, family medical programs, or Basic Food when:

(a) It is a resource we must count under WAC 388-470-0045 and 388-470-0055;

(b) You own the resource. We consider you to own a resource if:

(i) Your name is on the title to the property; or

(ii) You have property that doesn't have a title; and

(c) You have control over the resource, which means the resource is actually available to you; and

(d) You could legally sell the resource or convert it into cash within twenty days.

(3) For cash assistance and family medical programs, you must try to make your resources available even if it will take you more than twenty days to do so, unless:

(a) There is a legal barrier; or

(b) You must petition the court to release part or all of a resource.

(4) When you apply for assistance, we count your resources as of:

(a) The date of your interview, if you are required to have an interview; or

(b) The date of your application, if you are not required to have an interview; or

(c) The first day of the month of application, for medical assistance.

(5) If your total countable resources are over the resource limit in subsection (6) through (13) of this section, you are not eligible for benefits.

(6) For cash assistance and applicants for family medical programs, we use the equity value as the value of your resources.

(a) Applicants can have countable resources up to one thousand dollars.

(b) Recipients of cash assistance can have an additional three thousand dollars in a savings account.

(7) Recipients of family medical programs do not have a resource limit.

(8) We do not count your resources for children's medical or pregnancy medical benefits.

(9) For SSI-related medical assistance, see chapter 388-475 WAC.

(10) For clients receiving institutional or wavered services, see chapters 388-513 and 388-515 WAC.

(11) If your household consists of more than one medical assistance unit (MAU), as described in WAC 388-408-0055, we look at the resources for each MAU separately.

(12) If your AU is categorically eligible (CE) as described in WAC 388-414-0001, you do not have a resource limit for Basic Food.

(13) If your AU is not CE under WAC 388-414-0001, your AU may have countable resources up to the following amount and be eligible for Basic Food:

(a) Three thousand dollars if your AU has either an elderly or disabled individual; or

(b) Two thousand dollars for all other AUs.

(14) If you own a countable resource with someone who is not in your AU, we count the portion of the resource that you own. If we cannot determine how much of the resource is yours:

(a) For cash assistance, we count an equal portion of the resource that belongs to each person who owns it.

(b) For medical assistance and Basic Food, we count the entire amount unless you can prove that the entire amount is not available to you.

(15) We assume that you have control of community property and you can legally sell the property or convert it to cash unless you can show that you do not.

(16) We may not consider an item to be separate property if you used both separate and community funds to buy or improve it.

(17) We do not count the resources of victims of family violence when:

(a) The resource is owned jointly with members of the former household; or

(b) Availability of the resource depends on an agreement of the joint owner; or

(c) Making the resource available would place the client at risk of harm.

(18) You may give us proof about a resource anytime, including when we ask for it or if you disagree with a decision we made, about:

(a) Who owns a resource;

(b) Who has legal control of the resource;

(c) The value of a resource;

(d) The availability of a resource; or

(e) The portion of a property you or another person owns.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0005, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0012 Does the department look at the resources of people who are not getting benefits? Yes we do. We count the resources of certain people who live in your home, even if they are not getting assistance. Their resources count as part of your resources.

(1) For cash assistance, we count the resources of ineligible, disqualified, or financially responsible people as defined in WAC 388-450-0100.

(2) For Basic Food, we count the resources of ineligible assistance unit (AU) members as defined in WAC 388-408-0035.

(3) For family and SSI-related medical assistance, we count the resources of financially responsible people as defined in WAC 388-408-0055.

(4) For long term care services, we count the resources of financially responsible people as defined in WAC 388-506-0620.

(5) For cash assistance, medical assistance, and Basic Food, we also count the resources of an immigrant's sponsor as described in WAC 388-470-0060.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0012, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057 and 74.08.090. 99-09-053, § 388-470-0012, filed 4/19/99, effective 5/20/99.]

WAC 388-470-0026 Excluded resources for family medical programs. "Continuously eligible" means, for the purposes of this chapter, there has not been a break of a calendar month or more in a client's eligibility since the date the client received resources in an amount that would cause the client to exceed the resource limit of a family medical program.

(1) The department does not count any increase in a client's resources received while a client:

(a) Is eligible for and receiving coverage under a family medical program; and

(b) Remains continuously eligible for a family medical program.

(2) The department does not count the resource increase for a client:

(a) Who meets the requirement of subsection (1)(a) of this section;

(b) Whose family medical program is terminated; and

(c) Who is later found eligible for all months since the termination, which may include a retroactive period of up to three months.

(3) The department counts the resource increase when the client is ineligible for a family medical program for a full calendar month or more except as described in subsection (2) of this section.

(4) When determining the eligibility of a Holocaust survivor for a family medical program, the department does not count the recoveries of:

(a) Insurance proceeds; and

(b) Other assets.

(5) For the purposes of this section, a family medical program includes the medical extension benefits as described in WAC 388-523-0100.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0026, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-470-0026, filed 8/22/01, effective 9/22/01.]

WAC 388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs? (1) We count the following resources toward your assistance unit's resource limits for cash assistance and family medical programs to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources not specifically excluded in subsection (2) below. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Available retirement funds or pension benefits, less any withdrawal penalty;

(v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts; or

(vii) Lump sum payments as described in chapter 388-455 WAC.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) The amount of a child's irrevocable educational trust fund that is over four thousand dollars per child.

(e) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(f) Any real property like a home, land or buildings not specifically excluded in subsection (3) below.

(g) The equity value of vehicles as described in WAC 388-470-0070.

(h) Personal property that is not:

(i) A household good;

(ii) Needed for self-employment; or

(iii) Of "great sentimental value," due to personal attachment or hobby interest.

(i) Resources of a sponsor as described in WAC 388-470-0060.

(j) For cash assistance only, sales contracts.

(2) The following types of liquid resources do not count when we determine your eligibility:

(a) Bona fide loans, including student loans;

(b) Basic Food benefits;

(c) Income tax refunds in the month of receipt;

(d) Earned income tax credit (EITC) in the month received and the following month;

(e) Advance earned income tax credit payments;

(f) Individual development accounts (IDAS) established under RCW 74.08A.220;

(g) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(h) Underpayments received under chapter 388-410 WAC;

(i) Educational benefits that are excluded as income under WAC 388-450-0035;

(j) The income and resources of an SSI recipient;

(k) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(l) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(m) Adoption support payments;

(n) Self-employment accounts receivable that the client has billed to the customer but has been unable to collect; and

(o) Resources specifically excluded by federal law.

(3) The following types of real property do not count when we determine your eligibility:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis; or

(iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(5) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0045, filed 2/7/03, effective 3/1/03; 99-16-024, § 388-470-0045, 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, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0055 How do my resources count toward the resource limit for Basic Food? (1) For Basic Food, if your assistance unit (AU) is not categorically eligible (CE) under WAC 388-414-0001, we count the following resources toward your AU's resource limit to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(v) Available trusts or trust accounts; or

(vi) Lump sum payments. A lump sum payment is money owed to you from a past period of time that you get but do not expect to get on a continuing basis.

(b) Nonliquid resources, personal property, and real property not specifically excluded in subsection (2) below.

(c) Vehicles as described in WAC 388-470-0075.

(d) The resources of a sponsor as described in WAC 388-470-0060.

(2) The following resources do not count toward your resource limit:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis;

(iv) Is essential to the employment or self-employment of a household member. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing; or

(v) Is essential for the maintenance or use of an income-producing vehicle; or

(vi) Has an equity value equal to or less than half of the resource limit as described in WAC 388-470-0005.

(d) Household goods

(e) Personal effects;

(f) Life insurance policies, including policies with cash surrender value (CSV);

(g) One burial plot per household member;

(h) One funeral agreement per household member, up to fifteen hundred dollars;

(i) Pension plans or retirement funds not specifically counted in subsection (1) above;

(j) Sales contracts, if the contract is producing income consistent with its fair market value;

(k) Government payments issued for the restoration of a home damaged in a disaster;

(l) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs;

(m) Nonliquid resources that have a lien placed against them;

(n) Earned Income Tax Credits (EITC):

(i) For twelve months, if you were a Basic Food recipient when you got the EITC and you remain on Basic Food for all twelve months; or

(ii) The month you get it and the month after, if you were not getting Basic Food when you got the EITC.

(o) Energy assistance payments or allowances;

(p) The resources of a household member who gets SSI, TANF/SFA, or GA benefits;

(q) Retirement funds or accounts that are tax exempt under the Internal Revenue Code;

(r) Education funds or accounts in a tuition program under section 529 or 530 of the Internal Revenue Code; and

(s) Resources specifically excluded by federal law.

(3) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(4) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and Public Law 110-234. 08-18-043, § 388-470-0055, filed 8/29/08, effective 10/1/08. Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0055, filed 2/7/03, effective 3/1/03; 99-16-024, § 388-470-0055, 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, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0060 How does the department decide how much of my sponsor's resources affect my eligibility for cash, medical, and food assistance benefits? (1) If you are a sponsored immigrant as defined in WAC 388-450-0155, and you are not exempt from deeming under WAC 388-450-0156, we count part of your sponsor's resources as available to you.

(2) We decide the amount of your sponsor's resources to count by:

(a) Totaling the countable resources of the sponsor and the sponsor's spouse (if the spouse signed the affidavit of support) under chapter 388-470 WAC;

(b) Subtracting fifteen hundred dollars; and

(c) Counting the remaining amount as a resource that is available to you.

(3) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number of people who they sponsored.

(4) We continue to count your sponsor's resources when we determine your eligibility for benefits until you are exempt from deeming under WAC 388-450-0156.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-470-0060, filed 10/9/01, effective 11/1/01. Statutory Authority: RCW

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-510-1030.]

WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and family medical programs. (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation. Each separate medical assistance unit is allowed this exclusion.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0070, 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, § 388-470-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610.]

WAC 388-470-0075 How is my vehicle counted for the Washington Basic Food program? This rule applies to the Washington Basic Food program only.

(1) A vehicle is a motorized device that the client can use as a regular means of transportation.

(2) If you own a licensed vehicle we (the department) do not count its entire value if the vehicle:

(a) Has an equity value (fair market value (FMV) minus what you owe on the vehicle) of one thousand five hundred dollars or less.

(b) Is used over fifty percent of the time to make income. This includes vehicles such as a taxi, truck, or fishing boat. If you are a self-employed farmer or fisher and your self-employment ends, we still exclude your vehicle for one year from the date you end your self-employment.

(c) Is used to make income each year that is consistent with its FMV, even if used on a seasonal basis.

(d) Is needed for long-distance travel, other than daily commuting, for the employment of an assistance unit (AU).

(e) Is used as your AU's home.

(f) Is used to carry fuel for heating or water for home use when this is the primary source of fuel or water for your AU.

(g) Is needed to transport a physically disabled AU member, no matter if the disability is permanent or temporary.

(3) For licensed vehicles we did not exclude in subsection (2) above, we subtract four thousand six hundred fifty dollars from the vehicle's FMV and count the remaining amount toward the resource limit for:

(a) One vehicle for each adult AU member no matter how it is used; and

(b) Any vehicle an AU member under age eighteen uses to drive to work, school, training, or to look for work.

(4) If you have other licensed vehicles, we count the larger value of the following toward your AU's resource limit:

(a) FMV greater than four thousand six hundred fifty dollars; or

(b) Equity value (FMV minus what is owed on the vehicle).

(5) If you are a tribal member and drive an unlicensed vehicle on a reservation that does not require vehicle licensing, we count or exclude your vehicle as if it was a licensed vehicle.

(6) For all other unlicensed vehicles we count the equity value towards your AU's resource limit unless the vehicle is:

(a) Used to make income each year that is consistent with its FMV, even if used on a seasonal basis; or

(b) Work-related equipment needed for employment or self-employment of a member of your AU.

(7) We do not add the equity values of different vehicles together to perform the equity test. We look at each vehicle separately. If a vehicle passes the equity test, we do not count it towards the resource maximum.

(8) After we determine the countable value of each vehicle, we add those values to your other countable resources to see if your resources are below your resource limit.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-23-028, § 388-470-0075, filed 11/12/02, effective 12/1/02; 01-16-134, § 388-470-0075, filed 7/31/01, effective 11/1/01; 01-15-078, § 388-470-0075, filed 7/17/01, effective 8/1/01; 99-16-024, § 388-470-0075, 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, § 388-470-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-472 WAC
RIGHTS AND RESPONSIBILITIES

WAC

WAC 388-472-0005 What are my rights and responsibilities? For the purposes of this chapter, "we" and "us" refer to the department and "you" refers to the applicant or recipient.

(1) If you apply for or get cash, food or medical assistance benefits you have the right to:

(a) Have your rights and responsibilities explained to you and given to you in writing;

(b) Be treated politely and fairly no matter what your race, color, political beliefs, national origin, religion, age, gender, disability or birthplace;

(c) Request benefits by giving us an application form using any method listed under WAC 388-406-0010. You can ask for and get a receipt when you give us an application or other documents;

(d) Have your application processed as soon as possible. Unless your application is delayed under WAC 388-406-0040, we process your application for benefits within thirty days, except:

(i) If you are eligible for expedited services under WAC 388-406-0015, you get food assistance within five days. If we deny you expedited services, you have a right to ask that the decision be reviewed by the department within two working days from the date we denied your request for expedited services;

(ii) If you are pregnant and otherwise eligible, you get medical within fifteen working days.

(iii) General assistance (GAU), alcohol or drug addiction treatment (ADATSA), or medical assistance may take up to forty-five days; and

(iv) Medical assistance requiring a disability decision may take up to sixty days.

(e) Be given at least ten days to give us information needed to determine your eligibility and be given more time if you ask for it. If we do not have the information needed to decide your eligibility, then we may deny your request for benefits;

(f) Have the information you give us kept private. We may share some facts with other agencies for efficient management of federal and state programs;

(g) Ask us not to collect child support or medical support if you fear the noncustodial parent may harm you, your children, or the children in your care;

(h) Ask for extra money to help pay for temporary emergency shelter costs, such as an eviction or a utility shutoff, if you get TANF;

(i) Get a written notice, in most cases, at least ten days before we make changes to lower or stop your benefits;

(j) Ask for a fair hearing if you disagree with a decision we make. You can also ask a supervisor or administrator to review our decision or action without affecting your right to a fair hearing;

(k) Have interpreter or translator services given to you at no cost and without delay;

(l) Refuse to speak to a fraud investigator. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for benefits; and

(m) Get help from us to register to vote.

(2) If you get cash, food, or medical assistance, you are responsible to:

(a) Tell us if you are pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction so we can process your request for benefits as soon as possible;

(b) Report the following expenses so we can decide if you can get more food assistance:

(i) Shelter costs;

(ii) Child or dependent care costs;

(iii) Child support that is legally obligated;

(iv) Medical expenses; and

(v) Self-employment expenses.

(c) Report changes as required under WAC 388-418-0005 and 388-418-0007.

(d) Give us the information needed to determine eligibility;

(e) Give us proof of information when needed. If you have trouble getting proof, we help you get the proof or contact other persons or agencies for it;

(f) Cooperate in the collection of child support or medical support unless you fear the noncustodial parent may harm you, your children, or the children in your care;

(g) Apply for and get any benefits from other agencies or programs prior to getting cash assistance from us;

(h) Complete reports and reviews when asked;

(i) Look for, get, and keep a job or participate in other activities if required for cash or food assistance;

(j) Give your medical identification card or letter of eligibility from us to your medical care provider; and

(k) Cooperate with the quality control review process.

(3) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055. 08-18-007, § 388-472-0005, filed 8/22/08, effective 9/22/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-472-0005, filed 6/21/02, effective 7/1/02; 01-10-104, § 388-472-0005, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.08.090 and 74.04.-510. 99-17-025, § 388-472-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-472-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0430, 388-504-0440, 388-504-0450 and 388-505-0560.]

WAC 388-472-0010 What are necessary supplemental accommodation services? Necessary supplemental accommodation (NSA) services are services provided to you if you have a mental, neurological, physical or sensory impairment or other problems that prevent you from getting program benefits in the same way that an unimpaired person would get them.

NSA services include but are not limited to:

(1) Arranging for or providing help to complete and submit forms to us;

(2) Helping you give or get the information we need to decide or continue eligibility;

(3) Helping you request continuing benefits;

(4) If you miss an appointment or deadline, contacting you about the reason before we reduce or end your benefits;

(5) Explaining to you the reduction in or ending of your benefits (see WAC 388-418-0020);

(6) If we know you have a person who helps you with your applications, notifying them when we need information or when we are about to reduce or end your benefits;

(7) Assisting you with requests for fair hearings;

(8) Providing protective payments if needed; and

(9) On request, reviewing our decision to terminate, suspend or reduce your benefits.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057. 04-14-037, § 388-472-0010, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0010, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0020 How does the department decide if I am eligible for NSA services? When you, as head of household, apply for benefits either in person or by phone, we screen you to decide if you meet NSA requirements. We explain NSA services to you during the screening.

(1) We identify you as NSA if you:

(a) Say you need NSA services in order to have equal access to our programs and services;

(b) Have or claim to have a mental impairment;

(c) Have a developmental disability;

(d) Are disabled by alcohol or drug addiction;

(e) Are unable to read or write in any language; or

(f) Are a minor not residing with your parents.

(2) We identify you as NSA if we observe you to have cognitive limitations, whether or not you have a disability,

which may prevent you from understanding the nature of NSA services or affect your ability to access our programs. Cognitive limitations are limitations in your ability to communicate, understand, remember, process information, exercise judgement and make decisions, perform routine tasks or relate appropriately with others.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0020, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0030 How can I get NSA services? (1) After we screen you for NSA eligibility and initially identify your case as NSA, we mark your case file with a uniform NSA identifier.

(2) After you are initially identified as NSA, we complete an assessment to confirm your NSA designation.

(3) If the assessment confirms your NSA designation, we develop an accommodation plan that specifies the services we will provide to you to improve your access to our programs and services.

(4) If you are designated as NSA according to WAC 388-472-0020 (1) and (2), we include all the NSA services listed in WAC 388-472-0010 in your accommodation plan.

(5) Based on your request or a change in your needs, the NSA designation and the accommodation plan may be assessed and changed.

(6) Even if you are eligible to receive NSA services you may refuse NSA services.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0030, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0040 What are the department's responsibilities in giving NSA services to me? (1) All of our staff are continually responsible to identify you as possibly NSA eligible and assist you with NSA services.

(2) We provide a grace period to continue your financial, food or medical assistance when:

(a) We stop a benefit because we are unable to tell if you continue to qualify; and

(b) You provide proof you still qualify for the benefit within the twenty days right after the benefit stops. We restore lost benefits as follows:

(i) We reopen your medical assistance from the first of the month; and

(ii) We recalculate your cash and food assistance and issue you the correct amount without taking away any benefits as long as you were eligible to receive them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0040, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0050 What if I don't accept or follow through the program requirements because I'm not able to or I don't understand them? (1) We consider how your limitation or impairment affects your ability to accept and follow through on all program requirements. This can include, but is not limited to, your actions in failing to:

(a) Follow through with medical treatment;

(b) Follow through with referrals to other agencies;

(c) Provide timely income reports;

(d) Maintain employment;

(e) Participate in food assistance employment and training; or

(f) Participate in the WorkFirst program.

(2) If we decide your limitation was the cause of your refusal to accept or failure to follow through on these requirements, we will find that you have good cause and we will not take any adverse action.

(3) Following a finding of good cause not to have followed through with the requirement, we will review your accommodation plan to assure that all services necessary to enable you to meet the program requirements are being provided to you.

(4) If we are unable to accommodate your condition so that you are able to participate in program requirements, we will waive program requirements.

(5) If participation in program requirements is not waived, you must cooperate with program requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0050, filed 5/1/01, effective 6/1/01.]

Chapter 388-473 WAC
ONGOING ADDITIONAL REQUIREMENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-473-0030 Home-delivered meals as an ongoing additional requirement. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0030, filed 7/17/00, effective 9/1/00.] Repealed by 05-19-059, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.

WAC 388-473-0010 What are ongoing additional requirements and how do I qualify? "Ongoing additional requirement" means a need beyond essential food, clothing, and shelter needs and is necessary to help you continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Refugee cash;

(d) General assistance cash; or

(e) Supplemental Security Income (SSI).

(2) You apply for an ongoing additional requirement benefit by notifying staff who maintain your cash or medical assistance that you need additional help to live independently.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. We make the decision based on proof you provide of:

(a) The circumstances that create the need; and

(b) How the need affects your health, safety and ability to continue to live independently.

(4) We authorize ongoing additional requirement benefits by increasing your monthly cash assistance benefit.

(5) We use the following review cycle table to decide when to review your need for the additional benefit(s).

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA	6 Months
GA	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change
All	Any time need or circumstances are expected to change.

(6) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-19-059, § 388-473-0010, filed 9/16/05, effective 10/17/05; 01-01-070, § 388-473-0010, filed 12/12/00, effective 2/1/01; 00-15-053, § 388-473-0010, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0020 When do we authorize meals as an ongoing additional requirement? (1) We authorize additional requirement benefits for meals when we decide all of the following conditions are true:

(a) You meet the criteria in WAC 388-473-0020;

(b) You are physically or mentally impaired in your ability to prepare meals; and

(c) Getting help with meals would meet your nutrition or health needs and is not available to you through another federal or state source; such as the community options program entry system (COPES), medicaid personal care (MPC), or informal support, such as a relative or volunteer.

(2) When we decide to provide meals as an additional requirement, we choose whether to authorize this benefit as restaurant meals or home-delivered meals.

(3) We authorize restaurant meals when:

(a) You are unable to prepare some of your meals;

(b) You have some physical ability to leave your home; and

(c) Home-delivered meals are not available or would be more expensive.

(4) We authorize home-delivered meals when:

(a) You are unable to prepare any of your meals;

(b) You are physically limited in your ability to leave your home; and

(c) Home-delivered meals are available.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-19-059, § 388-473-0020, filed 9/16/05, effective 10/17/05; 00-15-053, § 388-473-0020, filed 7/17/00, effective 9/1/00.]

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.]

WAC 388-473-0050 Telephone services as an ongoing additional requirement. We authorize benefits for telephone services when we decide:

(1) Without a telephone, your life would be endangered, you could not live independently, or you would require a more expensive type of personal care; and

(2) You have applied for the Washington telephone assistance program (WTAP) through your local telephone company.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0050, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0060 Laundry as an ongoing additional requirement. We authorize benefits for laundry when we decide:

(1) You are not physically able to do your own laundry; or

(2) You do not have laundry facilities that are accessible to you due to your physical limitations.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0060, filed 7/17/00, effective 9/1/00.]

Chapter 388-474 WAC
SUPPLEMENTAL SECURITY INCOME

WAC

WAC 388-474-0001 What is Supplemental Security Income (SSI) and who can get it? (1) SSI is a federal cash benefit program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(2) You can get SSI if you have limited income and resources and if you are:

(a) Aged (sixty-five and older);

(b) Blind; or

(c) Disabled.

(3) The SSI program replaced state programs for aged, blind and disabled persons beginning in January 1974. If you received state assistance in December 1973 and you became eligible for SSI in January 1974, you are called a grandfathered client by the state and a mandatory income level (MIL) client by SSI. You must continue to meet the definition of blind or disabled that was in effect under the state plan in December 1973. These definitions can be found in the SSA

program operations manual system (POMS), see http://policy.ssa.gov/poms.nsf.

(4) If you are needed in the home to care for an eligible person, you are called an essential person. You are also called a grandfathered client.

(5) If you are an essential person you must have lived continuously with the eligible person since January 1974.

(6) If you are an SSI recipient and you have a spouse who does not qualify for SSI in their own right, you may be eligible for a state supplemental payment for your spouse (also referred to as an ineligible spouse).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0001, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055. 01-06-042, § 388-474-0001, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0005 What medical coverage does a Supplemental Security Income client, essential person, and an ineligible spouse get? (1) If you are an SSI client you automatically get categorically needy (CN) medical coverage (WAC 388-505-0110) unless you:

(a) Refuse to provide private medical insurance information; or

(b) Refuse to assign the right to recover insurance funds to the department (WAC 388-505-0540).

(2) If you are an essential person as described in WAC 388-474-0001 you get CN medical coverage as long as you continue to live with the SSI client.

(3) If you are an ineligible spouse you are not considered an SSI recipient. You must have your medical assistance determined separately.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0005, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0010 How does being a Supplemental Security Income (SSI) client affect your cash assistance eligibility? (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child (see WAC 388-408-0015; or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get general assistance (GA).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0010, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050. 01-19-023, § 388-474-0010, filed 9/12/01, effective 11/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0012 What is a state supplemental payment and who can get it? (1) The state supplemental payment (SSP) is a state-funded cash assistance program for certain clients who the Social Security Administration determines are eligible for Supplemental Security Income (SSI).

(2) You can get an SSP if:

(a) You are a grandfathered SSI recipient under WAC 388-474-0001;

(b) You are an individual with an ineligible spouse under WAC 388-474-0001;

(c) You receive SSI because you are age sixty-five or older under WAC 388-474-0001;

(d) You receive SSI because you are blind under WAC 388-474-0001;

(e) You are determined eligible for SSP by the division of developmental disabilities; or

(f) You are eligible for and receive SSI as a foster child receiving specific services through children's administration behavior rehabilitation services (BRS) for part or all of a month, and not eligible for foster care reimbursement under Title IV-E of the Social Security Act.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-07-031, § 388-474-0012, filed 3/9/05, effective 4/9/05; 03-21-125, § 388-474-0012, filed 10/20/03, effective 11/1/03; 03-03-114, § 388-474-0012, filed 1/21/03, effective 2/23/03.]

WAC 388-474-0015 What happens to my categorically needy (CN) medical coverage when my Supplemental Security Income (SSI) cash payment is terminated? (1) Your CN medical coverage (WAC 388-505-0110) continues after an SSI cash payment ends when:

(a) Countable income exceeds the SSI income standard due solely to the annual cost-of-living adjustment (COLA); or

(b) A timely request for a hearing has been filed. CN medical coverage is continued until Social Security Administration (SSA) makes a final decision on the hearing request and on any subsequent timely appeals.

(2) If your SSI ends your CN medical coverage continues for a period of up to one hundred twenty days while the department reviews your eligibility for other cash or medical programs.

(3) If you are a terminated SSI or SSI-related client, the department will review your disability status when:

(a) You present new medical evidence;

(b) Your medical condition changes significantly; or

(c) Your termination from SSI was not based on a review of current medical evidence.

(4) Children terminated from SSI due to loss of disabled status may be eligible for medical benefits under WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-20-070, § 388-474-0015, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0015, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-524-2405.]

WAC 388-474-0020 What can a general assistance-unemployable (GA-U) client expect when Supplemental Security Income (SSI) benefits begin? You can only get assistance to meet your basic needs from one government

source at a time (WAC 388-448-0210). If you are a GA-U client who begins setting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you got GA-U, you must repay the department the amount of GA-U paid to you for the matching time period.

(2) When you apply for GA-U you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to get GA-U assistance.

(3) You cannot use your GA-U money to replace money deducted from your SSI check to repay an SSI overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0020, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-475 WAC
SSI-RELATED MEDICAL AND (HWD) PROGRAM

WAC

WAC 388-475-0050 SSI-related medical—General information. (1) The department provides medical benefits under the categorically needy (CN) and medically needy (MN) SSI-related programs for SSI-related people, meaning those who meet at least one of the federal SSI program criteria as being:

(a) Age sixty-five or older;

(b) Blind with:

(i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(ii) A field of vision limitation so the widest diameter of the visual field subtends an angle no greater than twenty degrees.

(c) Disabled:

(i) "Disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which:

(A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months; or

(C) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(ii) Decisions on SSI-related disability are subject to the authority of:

(A) Federal statutes and regulations codified at 42 USC Sec 1382c and 20 CFR, parts 404 and 416, as amended; and

(B) Controlling federal court decisions, which define the OASDI and SSI disability standard and determination process.

(2) A denial of Title II or Title XVI federal benefits by SSA solely due to failure to meet the blindness or disability criteria is binding on the department unless the applicant's:

(a) Denial is under appeal in the reconsideration stage in SSA's administrative hearing process, or SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The department considers a client who meets the special requirements for SSI status under Sections 1619(a) or 1619(b) of the Social Security Act as an SSI recipient. Such a client is eligible for CN medical coverage under WAC 388-474-0005.

(4) Individuals referred to in subsection (1) must also meet appropriate eligibility criteria found in the following WAC and EA-Z Manual sections:

(a) For all programs:

(i) WAC 388-408-0055, Medical assistance units;

(ii) WAC 388-416-0015, Categorically needy and WAC 388-416-0020, Medically needy certification periods;

(iii) Program specific requirements in chapter 388-475 WAC;

(iv) WAC 388-490-0005, Verification;

(v) WAC 388-503-0505, General eligibility requirements for medical programs;

(vi) WAC 388-505-0540, Assignment of rights and cooperation;

(vii) Chapter 388-561 WAC, Trusts, annuities and life estates.

(b) For LTC programs:

(i) Chapter 388-513 WAC, Long-term care services

(ii) Chapter 388-515 WAC, Waiver services.

(c) For MN, chapter 388-519 WAC, Spenddown;

(d) For HWD, program specific requirements in chapter 388-475 WAC.

(5) Aliens who qualify for medicaid benefits, but are determined ineligible because of alien status may be eligible for programs as specified in WAC 388-438-0110.

(6) The department pays for a client's medical care outside of Washington according to WAC 388-501-0180.

(7) The department follows income and resource methodologies of the Supplemental Security Income (SSI) program defined in federal law when determining eligibility for SSI-related medical or Medicare Cost Savings programs unless the department adopts rules that are less restrictive than those of the SSI program.

(8) Refer to WAC 388-418-0025 for effects of changes on medical assistance for redetermination of eligibility.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0050, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0100 SSI-related medical—Categorically needy (CN) medical eligibility. (1) Categorically needy (CN) coverage is available for an SSI-related client who:

(a) Meets the criteria in WAC 388-475-0050, SSI-related medical—General information; or

(b) Meets the criteria for the state-funded general assistance - expedited medicaid disability (GA-X) program by meeting the:

(i) Requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(ii) SSI-related disability standards but who cannot get the SSI cash grant due solely to immigration status or sponsor deeming issues.

(2) To be eligible for SSI-related CN medical programs, a person must also have:

(a) Countable income and resources at or below the SSI-related CN medical monthly standard (refer to WAC 388-478-0080) or be eligible for an SSI cash grant but choose not to receive it; or

(b) Countable resources at or below the SSI resource standard and income above the SSI-related CN medical monthly standard, but the countable income falls below that standard after applying special income disregards as described in WAC 388-475-880; or

(c) Met requirements for long-term care (LTC) CN income and resource requirements that are found in chapters 388-513 and 388-515 WAC if wanting LTC or waiver services.

(3) An ineligible spouse of an SSI recipient is not eligible for noninstitutional SSI-related CN medical benefits. If an ineligible spouse of an SSI recipient has dependent children in the home, eligibility may be determined for family medical programs.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0100, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0150 SSI-related medical—Medically needy (MN) medical eligibility. (1) Medically needy (MN) medical coverage is available for any of the following:

(a) A person who is SSI-related and not eligible for CN medical coverage because they have countable income that is above the CN income standard (or for long-term care (LTC) clients, above the special income limit (SIL)):

(i) Their countable income is at or below MN standards, leaving them with no spenddown requirement; or

(ii) Their countable income is above MN standards requiring them to spenddown their excess income (see subsection (4) below). See WAC 388-475-0500 through 388-475-0800 for rules on determining countable income, and WAC 388-478-0080 for program standards or chapter 388-513 WAC for institutional standards.

(b) An SSI-related ineligible spouse of an SSI recipient;

(c) An adult who meets SSI program criteria but is not eligible for the SSI cash grant due to immigration status or sponsor deeming. See WAC 388-424-0010 for limits on eligibility for aliens;

(d) A person who meets the MN LTC services requirements of chapter 388-513 WAC and WAC 388-515-1540;

(e) A person who lives in an alternate living facility and meets the requirements of WAC 388-513-1305; or

(f) A person who meets resource requirements as described in chapter 388-475 WAC, elects and is certified for hospice services per chapter 388-551 WAC.

(2) Clients whose countable resources are above the SSI resource standards are not eligible for MN noninstitutional medical benefits. See WAC 388-475-0200 through 388-475-0550 to determine countable resources.

(3) Clients who qualify for services under long term care have different criteria and may spend down excess resources to become eligible for LTC institutional or waiver medical benefits. Refer to WAC 388-513-1315 and 388-513-1395.

(4) A client with income over the medically needy income limit (MNIL) may become eligible for MN coverage when they have incurred medical expenses that are equal to the excess income. This is the process of meeting spenddown. Refer to chapter 388-519 WAC for spenddown information.

(5) A client may be eligible for medical coverage for up to three months immediately prior to the month of application, if the client:

(a) Met all eligibility requirements for the months being considered; and

(b) Received medical services covered by medicaid during that time.

(6) A client eligible for MN without a spenddown is certified for up to twelve months. For an MN client with spenddown, refer to WAC 388-519-0110. For a long-term care MN client, refer to WAC 388-513-1305 and 388-513-1315.

(7) A client must reapply for each certification period. There is no continuous eligibility for MN. Although each additional certification period requires a new application, if the medical benefits have been closed less than thirty days, an eligibility review form may be used to reapply.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0150, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0200 SSI-related medical—Definition of resources. (1) A resource is any cash, other personal property, or real property that an applicant, recipient or other financially responsible person:

(a) Owns;

(b) Has the right, authority, or power to convert to cash (if not already cash); and

(c) Has the legal right to use for his/her support and maintenance.

(2) The value of a resource may change. However, the property (personal or real) still remains a resource.

(3) Some assets are not resources. Any asset that does not meet the criteria in subsection (1) above is not a resource.

(4) When an SSI-related client owns a bank account or time deposit jointly with others who are also SSI-related clients, we consider the funds as being available to the SSI-related individuals in equal shares, unless sufficient evidence to the contrary is provided.

(5) When an SSI-related client owns a bank account or time deposit jointly with others who are not SSI-related, we consider all funds in the joint account as available to the client unless sufficient evidence to the contrary is provided.

(6) When an SSI-related client jointly owns either real or personal property other than bank accounts or time deposits, the department considers that the client owns and has available only his or her fractional interest in the property unless sufficient evidence to the contrary is provided.

(7) A resource is countable toward the resource limit only if it is available and is not excluded.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0200, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0250 SSI-related medical—Ownership and availability of resources. (1) Personal or real property is available to the client if the client, client's spouse or other financially responsible person:

(a) Owns the property;

(b) Has the authority to convert the property into cash;

(c) Can expect to convert the property to cash within twenty working days; and

(d) May legally use the property for his/her support.

(2) A resource is considered available on the first day of the month following the month of receipt unless a rule about a specific type of resource provides for a different time period.

(3) A resource, which ordinarily cannot be converted to cash within twenty working days, is considered unavailable as long as a reasonable effort is being made to convert the resource to cash.

(4) A client may provide evidence showing that a resource is unavailable. A resource is not counted if a client shows sufficient evidence that the resource is unavailable.

(5) We do not count the resources of victims of family violence, as defined in WAC 388-452-0010, when:

(a) The resource is owned jointly with members of the former household;

(b) Availability of the resource depends on an agreement of the joint owner; or

(c) Making the resource available would place the client at risk of harm.

(6) The value of a resource is its fair market value minus encumbrances.

(7) Refer to WAC 388-470-0060 to consider additional resources when an alien has a sponsor.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0250, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0300 SSI-related medical—Resources eligibility. (1) At 12:00 a.m. on the first day of the month a client's countable resources must be at or below the resource standard to be eligible for noninstitutional medical benefits for that month. If the total of the client's countable resources is above the resource standard at 12:00 a.m. on the first day of the month, the client is ineligible for noninstitutional medical benefits for that entire month regardless of resource status at the time of application during that month. For resource eligibility relating to long-term care eligibility see chapter 388-513 WAC.

(2) An excluded resource converted to another excluded resource remains excluded.

(3) Cash received from the sale of an excluded resource becomes a countable resource the first of the month following conversion unless the cash is;

(a) Used to replace the excluded resource; or

(b) Invested in another excluded resource in the same month or within the longer time allowed for home sales under WAC 388-475-0350; or

(c) Spent.

(4) The unspent portion of a nonrecurring lump sum payment is counted as a resource on the first of the month following its receipt with the following exception: The unspent portion of any Title II (SSA) or Title XVI (SSI) retroactive payment is excluded as a resource for nine months following the month of receipt. These exclusions apply to lump sums received by the client, client's spouse or any other person who is financially responsible for the client.

(5) Clients applying for SSI-related medical coverage for long-term care (LTC) services must meet different resource rules. See chapter 388-513 WAC for LTC resource rules.

(6) The transfer of a resource without adequate consideration does not affect medical program eligibility except for LTC services described in chapters 388-513 and 388-515 WAC. In those programs, the transfer may make a client ineligible for medical benefits for a period of time. See WAC 388-513-1363 through 388-513-1366 for LTC rules.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.04.050, 74.09.500. 08-23-101, § 388-475-0300, filed 11/19/08, effective 12/20/08; 08-14-048, § 388-475-0300, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0300, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0350 SSI-related medical—Property and contracts excluded as resources. (1) The department does not count the following resources when determining eligibility for SSI-related medical assistance:

(a) A client's household goods and personal effects;

(b) One home (which can be any shelter), including the land on which the dwelling is located and all contiguous property and related out-buildings in which the client has ownership interest, when:

(i) The client uses the home as his or her primary residence; or

(ii) The client's spouse lives in the home; or

(iii) The client does not currently live in the home but the client or his/her representative has stated the client intends to return to the home; or

(iv) A relative, who is financially or medically dependent on the client, lives in the home and the client, client's representative, or dependent relative has provided a written statement to that effect.

(c) The value of ownership interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship to a co-owner due to loss of housing. Undue hardship would result if the co-owner:

(i) Uses the property as his or her principal place of residence;

(ii) Would have to move if the property were sold; and

(iii) Has no other readily available housing.

(2) Cash proceeds from the sale of the home described in subsection (1)(b) above are not considered if the client uses them to purchase another home by the end of the third month after receiving the proceeds from the sale.

(3) An installment contract from the sale of the home described in subsection (1)(b) above is not a resource as long as the person plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home, and does so within three full calendar months after the month of receiving such down payment or installment payment.

(4) The value of sales contracts is excluded when the:

(a) Current market value of the contract is zero,

(b) Contract cannot be sold, or

(c) Current market value of the sales contract combined with other resources does not exceed the resource limits.

(5) Sales contracts executed before December 1, 1993, are exempt resources as long as they are not transferred to someone other than a spouse.

(6) A sales contract for the sale of the client's principal place of residence executed between December 1, 1993 and May 31, 2004 is considered an exempt resource unless it has been transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property; and

(c) The term of the contract does not exceed thirty years.

(7) A sales contract executed on or after June 1, 2004 on a home that was the principal place of residence for the client at the time of institutionalization is considered exempt as long as it is not transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property within the anticipated life expectancy of the client; and

(c) The term of the contract does not exceed thirty years.

(8) Payments received on sales contracts of the home described in subsection (1)(b) above are treated as follows:

(a) The interest portion of the payment is treated as unearned income in the month of receipt of the payment;

(b) The principal portion of the payment is treated as an excluded resource if reinvested in the purchase of a new home within three months after the month of receipt;

(c) If the principal portion of the payment is not reinvested in the purchase of a new home within three months after the month of receipt, that portion of the payment is considered a liquid resource as of the date of receipt.

(9) Payments received on sales contracts described in subsection (4) are treated as follows:

(a) The principal portion of the payment on the contract is treated as a resource and counted toward the resource limit to the extent retained at the first moment of the month following the month of receipt of the payment; and

(b) The interest portion is treated as unearned income the month of receipt of the payment.

(10) For sales contracts that meet the criteria in subsections (5), (6), or (7) but do not meet the criteria in subsections (3) or (4), both the principal and interest portions of the payment are treated as unearned income in the month of receipt.

(11) Property essential to self-support is not considered a resource within certain limits. The department places property essential to self-support in several categories:

(a) Real and personal property used in a trade or business (income-producing property), such as:

(i) Land,

(ii) Buildings,

(iii) Equipment,

(iv) Supplies,

(v) Motor vehicles, and

(vi) Tools.

(b) Nonbusiness income-producing property, such as:

(i) Houses or apartments for rent, or

(ii) Land, other than home property.

(c) Property used to produce goods or services essential to an individual's daily activities, such as land used to produce vegetables or livestock, which is only used for personal consumption in the individual's household. This includes personal property necessary to perform daily functions including vehicles such as boats for subsistence fishing and garden tractors for subsistence farming, but does not include other vehicles such as those that qualify as automobiles (cars, trucks).

(12) The department will exclude an individual's equity in real and personal property used in a trade or business (income producing property listed in subsection (11)(a) above) regardless of value as long as it is currently in use in the trade or business and remains used in the trade or business.

(13) The department excludes up to six thousand dollars of an individual's equity in nonbusiness income-producing property listed in subsection (11)(b) above, if it produces a net annual income to the individual of at least six percent of the excluded equity.

(a) If a person's equity in the property is over six thousand dollars, only the amount over six thousand dollars is counted toward the resource limit, as long as the net annual income requirement of six percent is met on the excluded equity.

(b) If the six percent requirement is not met due to circumstances beyond the person's control, and there is a reasonable expectation that the activities will again meet the six percent rule, the same exclusions as in subsection (13)(a) above apply.

(c) If a person has more than one piece of property in this category, each is looked at to see if it meets the six percent return and the total equities of all those properties are added to see if the total is over six thousand dollars. If the total is over the six thousand dollars limit, the amount exceeding the limit is counted toward the resource limit.

(d) The equity in each property that does not meet the six percent annual net income limit is counted toward the resource limit, with the exception of property that represents the authority granted by a governmental agency to engage in an income-producing activity if it is:

(i) Used in a trade or business or nonbusiness income-producing activity; or

(ii) Not used due to circumstances beyond the individual's control, e.g., illness, and there is a reasonable expectation that the use will resume.

(14) Property used to produce goods or services essential to an individual's daily activities is excluded if the individual's equity in the property does not exceed six thousand dollars.

(15) Personal property used by an individual for work is not counted, regardless of value, while in current use, or if the required use for work is reasonably expected to resume.

(16) Interests in trust or in restricted Indian land owned by an individual who is of Indian descent from a federally recognized Indian tribe or held by the spouse or widow/er of that individual, is not counted if permission of the other individuals, the tribe, or an agency of the federal government must be received in order to dispose of the land.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0350, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0400 SSI-related medical—Vehicles excluded as resources. (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the individual or a member of the individual's household:

(a) For employment;

(b) For the treatment of a specific or regular medical problem;

(c) For transportation of or modified for operation by a handicapped person; or

(d) Because of climate, terrain, distance, or similar factors to perform essential daily activities.

(3) If no vehicle is excluded under subsection (2), the department excludes up to five thousand dollars of the current fair market value of one vehicle as a resource. If the current fair market value of the vehicle exceeds five thousand dollars, the excess is counted toward the resource limit.

(4) A vehicle used as the client's primary residence is excluded as the home, and does not count as the one excluded vehicle.

(5) All other vehicles, except those excluded under WAC 388-475-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0400, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0450 SSI-related medical—Life insurance excluded as a resource. (1) The department excludes life insurance policies that do not have or cannot accrue a cash surrender value (CSV) in determining whether owned policies exceed the life insurance exclusion limits for resources and in determining burial fund exclusion limits.

(2) Policies owned by each spouse are evaluated and counted separately.

(3) If the total face value of all policies with a CSV potential that a person owns on the same insured is equal to or less than fifteen hundred dollars, the resource is excluded.

(4) If the total face value of all policies with a CSV potential that a person owns on the same insured is more than fifteen hundred dollars, the total CSV of the policies is counted toward the resource limit, unless the client designates such policies as burial funds. If they are designated as burial funds, they must be evaluated under the burial fund exclusion described in WAC 388-475-0500.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0450, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources. (1) For the purposes of this section, burial funds are funds set aside and clearly designated solely for burial and related expenses and kept separate from all other resources not intended for burial. These include:

(a) Revocable burial contracts;

(b) Revocable burial trusts;

(c) Installment contracts for purchase of a burial space on which payments are still owing;

(d) Other revocable burial arrangements. The designation is effective the first day of the month in which the person intended the funds to be set aside for burial.

(2) The following burial funds are excluded as resources for the client and spouse up to fifteen hundred dollars each when set aside solely for the expenses of burial or cremation and expenses related to the burial or cremation, and the funds are either:

(a) An installment contract for purchase of a burial space that is not yet paid in full; or

(b) In a revocable burial contract, burial trust, cash accounts, or other financial instrument with a definite cash value.

(3) Interest earned in burial funds and appreciation in the value of excluded burial arrangements in subsection (2)(a) and (b) above are excluded from resources and are not counted as income if left to accumulate and become part of the separate burial fund.

(4) The fifteen hundred dollar exclusion for burial funds described in subsection (2) above is reduced by:

(a) The face value of life insurance with CSV excluded in WAC 388-475-0450; and

(b) Amounts in an irrevocable burial trust, or other irrevocable arrangement available to meet burial expenses, or burial space purchase agreement installment contracts on which money is still owing. If these reductions bring the balance of the available exclusion to zero, no additional funds can be excluded as burial funds.

(5) An irrevocable burial account, burial trust, or other irrevocable burial arrangement, set aside solely for burial and related expenses is not considered a resource. The amount set aside must be reasonably related to the anticipated death-related expenses in order to be excluded.

(6) A client's burial funds are no longer excluded when they are mixed with other resources that are not related to burial.

(7) When excluded burial funds are spent for other purposes, the spent amount is added to other countable resources

and any amount exceeding the resource limit is considered available income on the first of the month it is used. The amount remaining in the burial fund remains excluded.

(8) Burial space and accessories for the client and any member of the client's immediate family described in subsection (9) of this section are excluded. Burial space and accessories include:

(a) Conventional gravesites;

(b) Crypts, niches, and mausoleums;

(c) Urns, caskets and other repositories customarily used for the remains of deceased persons;

(d) Necessary and reasonable improvements to the burial space including, but not limited to:

(i) Vaults and burial containers;

(ii) Headstones, markers and plaques;

(iii) Arrangements for the opening and closing of the gravesite; and

(iv) Contracts for care and maintenance of the gravesite.

(e) A burial space purchase agreement that is currently paid for and owned by the client is also defined as a burial space. The entire value of the purchase agreement is excluded; as well as any interest accrued, which is left to accumulate as part of the value of the agreement. The value of this agreement does not reduce the amount of burial fund exclusion available to the client.

(9) Immediate family, for the purposes of subsection (8) of this section includes the client's:

(a) Spouse;

(b) Parents and adoptive parents;

(c) Minor and adult children, including adoptive and stepchildren;

(d) Siblings (brothers and sisters), including adoptive and stepsiblings;

(e) Spouses of any of the above.

None of the family members listed above, need to be dependent on or living with the client, to be considered immediate family members.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0500, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

(1) Resources necessary for a client who is blind or disabled to fulfill a department approved self-sufficiency plan.

(2) Retroactive payments from SSI or RSDI, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person financially responsible for the client;

(b) SSI payments for benefits due for the month(s) before the month of continuing payment;

(c) RSDI payments for benefits due for a month that is two or more months before the month of continuing payment; and

(d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.

(3) All resources specifically excluded by federal law, such as those described in subsections (4) through (11) as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) Payments made to Native Americans as listed in 20 CFR 416.1182, Appendix to subpart K, section IV, paragraphs (b) and (c), and in 20 CFR 416.1236.

(6) The following Native American/Alaska Native funds are excluded resources:

(a) Resources received from a Native Corporation under the Alaska Native Claims Settlement Act, including:

(i) Shares of stock held in a regional or village corporation;

(ii) Cash or dividends on stock received from the Native Corporation up to two thousand dollars per person per year;

(iii) Stock issued by a native corporation as a dividend or distribution on stock;

(iv) A partnership interest;

(v) Land or an interest in land; and

(vi) An interest in a settlement trust.

(b) All funds contained in a restricted Individual Indian Money (IIM) account.

(7) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(8) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(9) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(10) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(11) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(12) Earned income tax credit refunds and payments are excluded as resources for nine months after the month of receipt.

(13) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(14) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The client intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are considered as available resources when not used within the allowable time periods.

(15) Insurance proceeds or other assets recovered by a Holocaust survivor as defined in WAC 388-470-0026(4).

(16) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(17) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(18) SSA- or DVR-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled individuals to set aside resources necessary for the achievement of the plan's goals, are excluded.

(19) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(20) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that Code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(21) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(22) The following are among assets that are not considered resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets. For a more complete list please see POMS @ http://policy.ssa.gov/poms.nsf/lnx/0501130050.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0550, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0550, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0600 SSI-related medical—Definition of income. (1) Income is anything an individual receives in cash or in-kind that can be used to meet his/her needs for food, clothing, or shelter. Income can be earned or unearned.

(2) Some receipts are not income because they do not meet the definition of income above, including:

(a) Cash or in-kind assistance from federal, state, or local government programs whose purpose is to provide medical care or services;

(b) Some in-kind payments that are not food, clothing or shelter coming from nongovernmental programs whose purposes are to provide medical care or medical services;

(c) Payments for repair or replacement of an exempt resource;

(d) Refunds or rebates for money already paid;

(e) Receipts from sale of a resource; and

(f) Replacement of income already received. See 20 CFR 416.1103 for a more complete list of receipts that are not income.

(3) Earned income includes the following types of payments:

(a) Gross wages and salaries, including garnished amounts;

(b) Commissions and bonuses;

(c) Severance pay;

(d) Other special payments received because of employment;

(e) Net earnings from self-employment (WAC 388-475-0840 describes net earnings);

(f) Self-employment income of tribal members unless the income is specifically exempted by treaty;

(g) Payments for services performed in a sheltered workshop or work activities center;

(h) Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered; or

(i) In-kind payments made in lieu of cash wages, including the value of food, clothing or shelter.

(4) Unearned income is all income that is not earned income. Some types of unearned income are:

(a) Annuities, pensions, and other periodic payments;

(b) Alimony and support payments;

(c) Dividends and interest;

(d) Royalties (except for royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered which would be earned income);

(e) Capital gains;

(f) Rents;

(g) Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;

(h) Gifts;

(i) Inheritances; or

(j) Prizes and awards.

(5) Some items which may be withheld from income, but the department considers as received income are:

(a) Federal, state, or local income taxes;

(b) Health or life insurance premiums;

(c) SMI premiums;

(d) Union dues;

(e) Penalty deductions for failure to report changes;

(f) Loan payments;

(g) Garnishments;

(h) Child support payments, court ordered or voluntary (WAC 388-475-0900 has an exception for deemors);

(i) Service fees charged on interest-bearing checking accounts;

(j) Inheritance taxes;

(k) Guardianship fees if presence of a guardian is not a requirement for receiving the income.

(6) Countable income, for the purposes of this chapter, means all income that is available to the individual:

(a) If it cannot be excluded, and

(b) After deducting all allowable disregards and deductions.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0600, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0650 SSI-related medical—Available income. (1) Income is considered available to a client at the earliest of when it is:

(a) Received, or

(b) Credited to an individual's account, or

(c) Set aside for his or her use, or

(d) Can be used to meet the client's needs for food, clothing or shelter.

(2) Anticipated nonrecurring lump sum payments are treated as income in the month received, with the exception of those listed in WAC 388-475-0700(5), and any remainder is considered a resource in the following month.

(3) Reoccurring income is considered available in the month of normal receipt, even if the financial institution posts it before or after the month of normal receipt.

(4) In-kind income received from anyone other than a legally responsible relative is considered available income only if it is earned income.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0650, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0700 SSI-related medical—Income eligibility. (1) In order to be eligible, a client is required do everything necessary to obtain any income to which they are entitled including (but not limited to):

(a) Annuities,

(b) Pensions,

(c) Unemployment compensation,

(d) Retirement, and

(e) Disability benefits; even if their receipt makes the client ineligible for department services, unless the client can provide evidence showing good reason for not obtaining the benefits.

The department does not count this income until the client begins to receive it.

(2) Income is budgeted prospectively for all medical programs.

(3) Anticipated nonrecurring lump sum payments other than retroactive SSI/SSDI payments are considered income in the month received, subject to reporting requirements in WAC 388-418-0007(4). Any unspent portion is considered a resource the first of the following month.

(4) The department follows income and resource methodologies of the Supplemental Security Income (SSI) program defined in federal law when determining eligibility for SSI-related medical or medicare savings programs unless the department adopts rules that are less restrictive than those of the SSI program.

(5) Exceptions to the SSI income methodology:

(a) Lump sum payments from a retroactive SSDI benefit, when reduced by the amount of SSI received during the period covered by the payment, are not counted as income;

(b) Unspent retroactive lump sum money from SSI or SSDI is excluded as a resource for nine months following receipt of the lump sum; and

(c) Both the principal and interest portions of payments from a sales contract, that meet the definition in WAC 388-475-0350(10), are unearned income.

(6) To be eligible for categorically needy (CN) SSI-related medical coverage, a client's countable income cannot exceed the CN program standard described in:

(a) WAC 388-478-0065 through 388-478-0085 for noninstitutional medical unless living in an alternate living facility; or

(b) WAC 388-513-1305(2) for noninstitutional CN benefits while living in an alternate living facility; or

(c) WAC 388-513-1315 for institutional and waiver services medical benefits.

(7) To be eligible for SSI-related medical coverage provided under the medically needy (MN) program, a client must:

(a) Have countable income at or below the MN program standard as described in WAC 388-478-0070; or

(b) Satisfy spenddown requirements described in WAC 388-519-0110;

(c) Meet the requirements for noninstitutional MN benefits while living in an alternate living facility (ALF). See WAC 388-513-1305(3); or

(d) Meet eligibility for the MN waiver program. See WAC 388-515-1540 and 388-515-1550.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0700, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0700, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0750 SSI-related medical—Countable unearned income. The department counts unearned income for SSI-related medical programs as follows:

(1) The total amount of benefits to which a client is entitled is available unearned income even when the benefits are:

(a) Reduced through the withholding of a portion of the benefit amount to repay a legal obligation;

(b) Garnished to repay a debt, other legal obligation, or make any other payment such as payment of medicare premiums.

(2) Payments received on a loan:

(a) Interest paid on the loan amount is considered unearned income; and

(b) Payments on the loan principal are not considered income. However, any amounts retained on the first of the following month are considered a resource.

(3) Money borrowed by a person, which must be repaid, is not considered income. It is considered a loan. If the money received does not need to be repaid, it is considered a gift.

(4) Rental income received for the use of real or personal property, such as land, housing or machinery is considered unearned income. The countable portion of rental income received is the amount left after deducting necessary expenses of managing and maintaining the property paid in that month or carried over from a previous month. Necessary expenses are those such as:

(a) Advertising for tenants;

(b) Property taxes;

(c) Property insurance;

(d) Repairs and maintenance on the property; and

(e) Interest and escrow portions of a mortgage.

NOTE: When a client is in the business of renting properties and actively works the business (over twenty hours per week), the income is counted as earned income.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0750, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0800 SSI-related medical—General income exclusions. The department excludes, or does not consider, the following when determining a client's eligibility for SSI-related medical programs:

(1) The first twenty dollars per month of unearned income. If there is less than twenty dollars of unearned income in a month, the remainder is excluded from earned income in that month.

(a) The twenty-dollar limit is the same, whether applying it for a couple or for a single person.

(b) The disregard does not apply to income paid totally or partially by the federal government or a nongovernmental agency on the basis of an eligible person's needs.

(c) The twenty dollars disregard is applied after all exclusions have been taken from income.

(2) Income that is not reasonably anticipated or is received infrequently or irregularly, whether for a single person or each person in a couple when it is:

(a) Earned and does not exceed a total of thirty dollars per calendar quarter; or

(b) Unearned and does not exceed a total of sixty dollars per calendar quarter;

(c) Increases in a client's burial funds that were established on or after November 1, 1982 if the increases are the result of:

(i) Interest earned on excluded burial funds; or

(ii) Appreciation in the value of an excluded burial arrangement that was left to accumulate and become part of separately identified burial funds.

(3) Essential expenses necessary for a client to receive compensation (e.g., necessary legal fees in order to get a settlement);

(4) Receipts, which are not considered income, when they are for:

(a) Replacement or repair of an exempt resource;

(b) Prepayment or repayment of medical care paid by a health insurance policy or medical service program; or

(c) Payments made under a credit life or credit disability policy.

(5) The fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the client to receive payment of the income.

(6) Funds representing shared household costs.

(7) Crime victim's compensation.

(8) The value of a common transportation ticket, given as a gift, that is used for transportation and not converted to cash.

(9) Gifts that are not for food, clothing or shelter, and gifts of home produce used for personal consumption.

(10) The department does not consider in-kind income received from someone other than a person legally responsible for the individual unless it is earned. Therefore, the following in-kind payments are not counted when determining eligibility for SSI-related medical programs.

(a) In-kind payments for services paid by a client's employer if:

(i) The service is not provided in the course of an employer's trade or business; or

(ii) It is in the form of food and/or shelter that is:

(A) On the employer's business premises;

(B) For the employer's convenience; and

(C) If shelter, acceptance by the employee is a condition of employment.

(b) In-kind payments made to people in the following categories:

(i) Agricultural employees;

(ii) Domestic employees;

(iii) Members of the uniformed services;

(iv) Persons who work from home to produce specific products for the employer from materials supplied by the employer.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0800, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0800, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0820 SSI-related medical—Child-related income exclusions. (1) The department excludes an allowance from a person's earned and/or unearned income for a child living in the home when:

(a) The minor child lives with an SSI-related parent; and

(b) The minor child is not receiving a needs-based cash payment such as TANF or SSI; and

(c) The SSI-related parent is single; or

(d) The SSI-related parent lives with a spouse who has no income; and

(e) The individual applying for or receiving SSI-related medical benefits is the adult parent. The maximum allowance

is one-half the Federal Benefit Rate (FBR) for each child. The child's countable income, if any, is subtracted from the maximum child's allowance before determining this allowance.

(2) Foster care payments received for a child who is not SSI-eligible and who is living in the household, placed there by a licensed, nonprofit or public child placement or child-care agency are excluded from income regardless of whether the person requesting or receiving SSI-related medical is the adult foster parent or the child who was placed.

(3) Adoption support payments, received by an adult for a child in the household that are designated for the child's needs, are excluded as income. Adoption support payments that are not specifically designated for the child's needs are not excluded and are considered unearned income to the adult.

(4) Earned income of a person under age twenty-two is excluded if that person is a student.

(5) Child support payments received from an absent parent for a child living in the home are considered the income of the child.

(6) One-third of child support payments received for a child are excluded from the child's income.

(7) Any portion of a grant, scholarship, fellowship, or gift used for tuition, fees and/or other necessary educational expenses at any educational institution is excluded from income for nine months after the month of receipt.

(8) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that Code, is excluded as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(9) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children are excluded from income.

(10) Unless it is specifically contributed to the client, all earned income of an ineligible or nonapplying person under the age of twenty-one who is a student:

(a) Attending a school, college, or university; or

(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0820, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0820, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0840 SSI-related medical—Work- and agency-related income exclusions. The department excludes the following when determining eligibility for SSI-related medical programs:

(1) Work related expenses:

(a) Including child care, that enable an SSI-related client to work;

(b) That allow a blind or disabled client to work and that are directly related to the person's impairment.

(2) First sixty-five dollars plus one-half of the remainder of earned income. This is considered a work allowance/ incentive. This deduction does not apply to income already excluded.

(3) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS).

(4) Veteran's Aid and Attendance, housebound allowance, unusual/unreimbursed medical expenses (UME) paid by the VA to some disabled veterans, their spouses, widows or parents. For people receiving long-term care services, see chapter 388-513 WAC.

(5) Payments provided in cash or in-kind, to an ineligible or nonapplying spouse, under any government program that provides social services provided to the client, such as chore services or attendant care.

(6) SSA refunds for medicare buy-in premiums paid by the client when the state also paid the premiums.

(7) Income that causes a client to lose SSI eligibility, due solely to reduction in the SSP.

(8) Department of Veteran's Affairs benefits designated for the veteran's dependent. It is considered income of that dependent.

(9) Tax rebates or special payments excluded under other statutes.

(10) Any public agency refund of taxes paid on real property or on food.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0840, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0860 SSI-related medical—Income exclusions under federal statute or other state laws. The Social Security Act and other federal statutes or state laws list income that the department excludes when determining eligibility for SSI-related medical programs. These exclusions include, but are not limited to:

(1) Income tax refunds;

(2) Federal earned income tax credit (EITC) payments for nine months after the month of receipt;

(3) Compensation provided to volunteers in the Corporation for National and Community Service (CNCS), formerly known as ACTION programs established by the Domestic Volunteer Service Act of 1973. P.L. 93-113;

(4) Assistance to a person (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102 (h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a);

(5) Federal, state and local government payments including assistance provided in cash or in-kind under any government program that provides medical or social services;

(6) Certain cash or in-kind payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(7) Value of food provided through a federal or nonprofit food program such as WIC, donated food program, school lunch program;

(8) Assistance based on need, including:

(a) Any federal SSI income or state supplement payment (SSP) based on financial need;

(b) Food stamps;

(c) GA-U;

(d) CEAP;

(e) TANF; and

(f) Bureau of Indian Affairs (BIA) general assistance.

(9) Housing assistance from a federal program such as HUD if paid under:

(a) United States Housing Act of 1937 (section 1437 et seq. of 42 U.S.C.);

(b) National Housing Act (section 1701 et seq. of 12 U.S.C.);

(c) Section 101 of the Housing and Urban Development Act of 1965 (section 1701s of 12 U.S.C., section 1451 of 42 U.S.C.);

(d) Title V of the Housing Act of 1949 (section 1471 et seq. of 42 U.S.C.); or

(e) Section 202(h) of the Housing Act of 1959;

(f) Weatherization provided to low-income homeowners by programs that consider income in the eligibility determinations;

(10) Energy assistance payments including:

(a) Those to prevent fuel cutoffs, and

(b) To promote energy efficiency.

(11) Income from employment and training programs as specified in WAC 388-450-0045.

(12) Foster grandparents program;

(13) Title IV-E and state foster care maintenance payments if the foster child is not included in the assistance unit;

(14) The value of any childcare provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by section 8(b) of P.L. 102-586 (106 Stat. 5035).

(15) Educational assistance as specified in WAC 388-450-0035.

(16) Up to two thousand dollars per year derived from an individual's interest in Indian trust or restricted land.

(17) Native American benefits and payments as specified in WAC 388-450-0040 and other Native American payments excluded by federal statute. For a complete list of these payments, see 20 CFR 416, Subpart K, Appendix, IV.

(18) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill) (May 8, 1997) settlement funds;

(19) Payments from Ricky Ray Hemophilia Relief Fund Act of 1998, P.L. 105-369;

(20) Disaster assistance paid under Federal Disaster Relief P.L. 100-387 and Emergency Assistance Act, P.L. 93-288 amended by P.L. 100-707 and for farmers P.L. 100-387;

(21) Payments to certain survivors of the Holocaust as victims of Nazi persecution; payments excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, P.L. 103-286 (108 Stat. 1450);

(22) Payments made under section 500 through 506 of the Austrian General Social Insurance Act;

(23) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(24) Restitution payments and interest earned to Japanese Americans or their survivors, and Aleuts interned during World War II, established by P.L. 100-383;

(25) Payments made from the Agent Orange Settlement Funds or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(26) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(27) Any interest or dividend is excluded as income, except for the community spouse of an institutionalized individual.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0860, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0860, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0880 SSI-related medical—Special income disregards. Portions of your income the department otherwise counts are disregarded when determining eligibility for SSI-related medical programs.

(1) The department disregards the following for SSI-related medical programs:

(a) The cost of living adjustment(s) (COLA) for a client who:

(i) Is currently receiving a Social Security payment;

(ii) Was eligible for and received both SSA and SSI/State Supplement payments (SSP) in the same month for at least one month since April, 1977; and

(iii) Would continue to receive SSI/SSP payments but for the COLA increase(s) to their SSA benefits. This is commonly known as the adjustment for "Pickle people."

(b) Widow(er)'s benefits for a client who:

(i) Was entitled to SSA title II (widow/widower's) benefits in December 1983;

(ii) Was at least fifty years old, but not yet sixty at that time;

(iii) Received title II benefits and SSI in January 1984;

(iv) Would continue to be eligible for SSI/SSP payments if the title II benefits were disregarded; and

(v) Filed an application for medicaid with the state by July 1, 1988.

(c) Widow, Widower or Surviving Divorced Spouse (title II) benefits for a client who:

(i) Received SSI/SSP benefits the month prior to receipt of title II benefits;

(ii) Would continue to be eligible for SSI/SSP benefits if the title II benefits or the COLA(s) to those benefits were disregarded;

(iii) Is not eligible for medicare Part A. This client is considered an SSI recipient until becoming entitled to medicare Part A.

(2) A disabled adult child (DAC) who is ineligible for SSI/SSP solely due to receipt of either Social Security benefits as a disabled adult child of a person with a Social Security account or due to receipt of a COLA to the DAC benefits, may be income eligible for CN medical if disregarding the SSA DAC benefits and COLA brings countable income below the CN standards, and the client:

(a) Is eighteen years of age or older;

(b) Remains related to the SSI program through disability or blindness;

(c) Lost SSI eligibility on or after July 1, 1988 due solely to the receipt of DAC benefits from SSA or a COLA to those benefits; and

(d) Meets the other SSI-related CN medical requirements.

(3) Clients who stop receiving an SSI cash payment due to earnings, but still meet all of the other SSI eligibility rules and have income below the higher limit established by the Social Security Act's Section 1619(b) are eligible for continued CN medicaid.

(4) TANF income methodology is used to determine countable income for children and pregnant women applying for MN unless the SSI methodology would be more beneficial to the client. For cases using TANF methodology, follow the family medical rules and allow the:

(a) Fifty percent earned income disregard;

(b) Child care and dependent care expenses related to employment; and

(c) Child support actually paid.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0880, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0900 SSI-related medical—Allocating income. The department considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) When income is allocated from an SSI-related person to other household members, that income is considered as the other members' income.

(2) A portion of the income of a spouse or parent is allocated to the needs of an SSI-related applicant when the spouse or parent is:

(a) Financially responsible for the SSI-related person as described in WAC 388-408-0055 and 388-506-0620. For long-term care programs, see WAC 388-513-1315, 388-513-1330, 388-513-1350; for waiver programs see WAC 388-515-1505 through 388-515-1530;

(b) Living in the same household;

(c) Not receiving SSI; and

(d) Either not related to SSI or is not applying for medical assistance.

(3) Allocations to children are deducted from the nonapplying spouse's unearned income, then from their earned income, before they are deducted from the applicant's income. See WAC 388-475-0820.

(4) If the conditions in subsection (2) are met, the income to be allocated from a parent to an SSI-related minor child applying for medical benefits is the amount remaining after deducting:

(a) All allowable income exclusions and disregards as described in WAC 388-475-750 through 388-475-880;

(b) One-half of the federal benefit rate (FBR) for each SSI ineligible sibling of the SSI related child living in the household, minus any countable income of that child. See WAC 388-478-0055 for FBR amount;

(c) The parent's allowance, either the one person FBR for a single parent or two person FBR for a two-parent household.

(5) A portion of the countable income of a nonapplying spouse remaining after the deductions in subsection (4) may be allocated to the SSI-related spouse as follows for CN medical determinations:

(a) If the income is less than or equal to one-half of the FBR after allowing the income exclusions in subsection (4) of this section, no income is allocated to the client.

(b) If the income is equal to or more than one-half of the FBR after allowing the income exclusions in subsection (4) of this section, all income other than the excluded amounts is allocated to the applying spouse.

(6) Deductions from the income of the nonapplying spouse of an SSI-related applicant for CN medical determinations are:

(a) Income exclusions as described in WAC 388-475-0750 through 388-478-0880;

(b) One-half of the federal benefit rate (FBR) as described in WAC 388-478-0055 for each eligible child in the household, minus the child's countable income.

(7) In determining MN medical eligibility for SSI-related applicants:

(a) If the income of the nonapplying spouse is less than the MNIL (see WAC 388-478-0070) after applying any child allocation, a portion of the applying spouse's countable income is added to the nonapplying spouse's income to raise it to the MNIL for MN;

(b) If the income of the nonapplying spouse is more than the MNIL after applying any child allocation, the entire amount exceeding the MNIL is allocated to the applying spouse.

(8) Only income and resources actually contributed to an alien applicant from their sponsor are counted as income. For allocation of income from an alien sponsor, refer to WAC 388-450-0155.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0900, filed 4/7/04, effective 6/1/04.]

WAC 388-475-1000 Healthcare for workers with disabilities (HWD)—Program description. This section describes the healthcare for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) scope of care as described in WAC 388-501-0060.

(2) The department approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 388-475-1100 for "retroactive" coverage for months before the month of application.

(3) A person who is eligible for another medicaid program may choose not to participate in the HWD program.

(4) A person is not eligible for HWD coverage for a month in which the person received medicaid benefits under the medically needy (MN) program.

(5) The HWD program does not provide long-term care (LTC) services described in chapters 388-513 and 388-515 WAC. LTC services include institutional, waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-475-1000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1000, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1050 Healthcare for workers with disabilities (HWD)—Program requirements. This section describes requirements a person must meet to be eligible for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 388-503-0505 (3)(a) through (f);

(b) Be age sixteen through sixty-four;

(c) Meet the federal disability requirements described in WAC 388-475-1150;

(d) Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 388-478-0075 for FPL amounts for medical programs); and

(e) Be employed full or part time (including self-employment) as described in WAC 388-475-1200.

(2) To determine net income, the department applies the following rules to total gross household income in this order:

(a) Deduct income exclusions described in WAC 388-475-0800, 388-475-0820, 388-475-0840, and 388-475-0860; and

(b) Follow the CN income rules described in:

(i) WAC 388-475-0600, SSI-related medical—Definition of income;

(ii) WAC 388-475-0650, SSI-related medical—Available income;

(iii) WAC 388-475-0700 (1) through (5), SSI-related medical—Income eligibility;

(iv) WAC 388-475-0750, SSI-related medical—Countable unearned income; and

(v) WAC 388-506-0620, SSI-related medical clients.

(3) The HWD program does not require an asset test.

(4) Once approved for HWD coverage, a person must pay his/her monthly premium in the following manner to continue to qualify for the program:

(a) The department calculates the premium for HWD coverage according to WAC 388-475-1250;

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again; and

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

[Statutory Authority: RCW 74.08.090, 34.05.353 and Section 1902 (a)(10)(A)(ii) of the Social Security Act. 04-15-002, § 388-475-1050, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1050, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1100 Healthcare for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the healthcare for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. The department cannot approve HWD coverage for a month that precedes January 1, 2002.

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 388-475-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the department denies retroactive coverage and refunds any payment received for those months.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1100, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1150 Healthcare for workers with disabilities (HWD)—Disability requirements. This section describes the disability requirements for the two groups of individuals that may qualify for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must meet the requirements of the Social Security Act in section 1902 (a) (10) (A) (ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the division of disability determination services (DDDS) to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1)(b).

(4) When completing a disability determination for the HWD program, DDDS will not deny disability status because of employment.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1150, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1200 Healthcare for workers with disabilities (HWD)—Employment requirements. This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the healthcare for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1200, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1250 Healthcare for workers with disabilities (HWD)—Premium payments. This section describes how the department calculates the premium amount a person must pay for healthcare for workers with disabilities (HWD) coverage. This section also describes program requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the department counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the department applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 388-475-0600(5), 388-475-0650, and 388-475-0700(1).

(b) Loans and certain other receipts are not considered to be income as described in 20 C.F.R. Sec. 416.1103, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid.

(3) The HWD premium amount equals a total of the following (rounded down to the nearest whole dollar):

(a) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 388-478-0070; plus

(b) Five percent of total unearned income; plus

(c) Two point five percent of earned income after first deducting sixty-five dollars.

(4) When determining the premium amount, the department will use the current income amount until a change in income is reported and processed.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the department will bill for HWD premiums during the month following the month in which coverage is approved.

(7) For retroactive coverage, the department will bill the HWD premiums during the month following the month in which coverage is requested and necessary information is received.

(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following month(s).

(9) As described in WAC 388-475-1050 (4)(b), the department will close HWD coverage after four consecutive months for which premiums are not paid in full.

(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.

(11) The department first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage.

[Statutory Authority: RCW 74.08.090, 34.05.353 and Section 1902 (a)(10)(A)(ii) of the Social Security Act. 04-15-002, § 388-475-1250, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1250, filed 12/14/01, effective 1/14/02.]

Chapter 388-476 WAC
SOCIAL SECURITY NUMBER

WAC

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program;

(d) The state-funded pregnant woman program; and

(e) Detoxification services.

[Statutory Authority: RCW 74.08.090. 03-20-061, § 388-476-0005, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

Chapter 388-478 WAC
STANDARDS FOR PAYMENTS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-478-0025 TANF payment standards for recent arrivals to Washington state. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.] Repealed by 99-16-024, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.08.090 and 74.04.510.

388-478-0026 Excluded resources for family medical programs. [Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and 2000 c 218. 00-21-063, § 388-478-0026, filed 10/16/00, effective 12/1/00.] Repealed by 02-05-004, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.08.090.

388-478-0056 SSI state supplement standards. [Statutory Authority: RCW 74.04.620, 74.04.630. 00-24-056, § 388-478-0056, filed 11/30/00, effective 1/1/01.] Repealed by 01-08-015, filed 3/23/01, effective 5/1/01. Statutory Authority: RCW 74.08.090, 74.04.057.

WAC 388-478-0005 Cash assistance need and payment standards and grant maximum. (1) Need standards for cash assistance programs represent the amount of income required by individuals and families to maintain a minimum and adequate standard of living. Need standards are based on assistance unit size and include basic requirements for food, clothing, shelter, energy costs, transportation, household maintenance and operations, personal maintenance, and necessary incidentals.

(2) Payment standards for assistance units in medical institutions and other facilities are based on the need for clothing, personal maintenance, and necessary incidentals (see WAC 388-478-0040 and 388-478-0045).

(3) Need and payment standards for persons and families who do not reside in medical institutions and other facilities are based on their obligation to pay for shelter.

(a) Eligibility and benefit levels for persons and families who meet the requirements in WAC 388-478-0010 are determined using standards for assistance units with an obligation to pay shelter costs.

(b) Eligibility and benefit levels for all other persons and families are determined using standards for assistance units who have shelter provided at no cost.

(c) For recent arrivals to Washington state who apply for temporary assistance for needy families (TANF), see WAC 388-468-0005.

(4) The monthly grant for an assistance unit containing eight or more persons cannot exceed the grant maximum payment standard for a family of eight listed in WAC 388-478-0020(1).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.100, 74.04.770, 74.08.090, and 2008 c 329 § 207 (1)(e). 08-21-134, § 388-478-0005, filed 10/20/08, effective 10/28/08. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057. 04-05-010, § 388-478-0005, 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, § 388-478-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0010 Households with obligations to pay shelter costs. The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs. An assistance unit has an obligation to pay shelter costs if one of the members:

(1) Owns, purchases or rents their place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment instead of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0010, 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, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

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	$1,131
2	1,431

Assistance Unit Size	Need Standard
3	1,767
4	2,085
5	2,403
6	2,721
7	3,145
8	3,480
9	3,816
10 or more	4,152

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$600
2	759
3	937
4	1,106
5	1,275
6	1,444
7	1,669
8	1,847
9	2,025
10 or more	2,203

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 08-24-070, § 388-478-0015, filed 12/1/08, effective 1/1/09; 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 388-478-0020 Payment standards for TANF, SFA, and RCA. (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$359	6	$866
2	453	7	1,000
3	562	8	1,107
4	661	9	1,215
5	762	10 or more	1,321

(2) The payment standards for TANF, SFA, and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$218	6	$526
2	276	7	608
3	341	8	673
4	402	9	739
5	464	10 or more	803

[Statutory Authority: RCW 74.04.050, 74.04.055, and 2008 c 329 § 207 (1)(e). 08-16-105, § 388-478-0020, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710.]

WAC 388-478-0030 Payment standards for GA-U and ADATSA. (1) The payment standards for general assistance - unemployable (GA-U) and alcohol and drug addiction treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$339
2	428

(2) The payment standards for GA-U and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$206
2	261

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0035 Maximum earned income limits for TANF, SFA and RCA. To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	$718	6	$1,732
2	906	7	2,000
3	1,124	8	2,214
4	1,322	9	2,430
5	1,524	10 or more	2,642

[Statutory Authority: RCW 74.04.050, 74.04.055, and 2008 c 329 § 207 (1)(e). 08-16-105, § 388-478-0035, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0040 Payment standard for persons in medical institutions. (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).

(2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0045 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in the following facilities:

(a) Congregate care facilities (CCF);

(b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and

(c) Division of developmental disabilities (DDD) group home facilities.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0050 Payment standards for ongoing additional requirements. An **"ongoing additional requirement"** is a continuing need that you have for which you require additional financial benefits in order to continue living independently. The **"payment standard"** for ongoing additional requirement benefits is the amount of money needed to pay for these items or services. We use the following payment standards for ongoing additional requirements approved under WAC 388-473-0020 through 388-473-0060:

(1) Restaurant meals: $187.09 per month (or $6.04 per day with the payment rounded down to the nearest dollar amount);

(2) Laundry: $11.13 per month;

(3) Service animal food: $33.66 per month;

(4) Home delivered meals: The amount charged by the agency providing the meals;

(5) Telephone: The local telephone flat rate for the area; or the Washington telephone assistance program (WTAP) rate, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-052, § 388-478-0050, filed 7/17/00, effective 9/1/00; 98-16-044, § 388-478-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

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
Grandfathered (MIL)	Varies by individual based on federal requirements. Payments range between $0.54 and $199.77.

Medical institution	Monthly SSP Rate
Individual	$27.28

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 2008 c 329 § 207(8). 08-16-067, § 388-478-0055, filed 7/31/08, effective 9/1/08. 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 388-478-0057 Year-end adjustments to the SSI state supplement. For the purposes of this rule, "we" refers to the department of social and health services. We are required by federal law to maintain the total SSI state supplement payments at the same level each year, without an increase or decrease in total spending. This may result in adjustment to your SSI state supplement benefits at the end of the year.

(1) If there are unexpended funds, you will receive a one-time bonus payment, usually at the end of the calendar year.

(2) When there is a shortage in available funds, your state supplement benefits will be decreased. The decrease will usually be spread out over multiple months to reduce the negative impact on you.

[Statutory Authority: RCW 74.08.090, 74.04.057. 01-22-088, § 388-478-0057, filed 11/5/01, effective 12/6/01.]

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 10-1-2008

Column A Number of Eligible AU Members	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	$1,127	$867	$176	$1,430
2	1,517	1,167	323	1,925
3	1,907	1,467	463	2,420
4	2,297	1,767	588	2,915
5	2,687	2,067	698	3,410
6	3,077	2,367	838	3,905
7	3,467	2,667	926	4,400
8	3,857	2,967	1,058	4,895
9	4,247	3,267	1,190	5,390
10	4,637	3,567	1,322	5,885
Each Additional Member	+390	+300	+132	+495

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 74.08.090. 08-24-050, § 388-478-0060, filed 11/25/08, effective 12/26/08. 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, 74.04.500, 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.]

WAC 388-478-0065 Income and resource standards for family medical programs. (1) The categorically needy income level (CNIL) standard for family medical is the same as the grant payment standards for the TANF cash program as stated in WAC 388-478-0020.

(2) The countable resource standards for family medical are the same as those of the TANF/SFA cash program as stated in WAC 388-470-0005.

(3) Each unborn child is counted as a household member when determining household size for:

(a) Family medical;

(b) Pregnancy medical; and

(c) Children's medical.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-15-080, § 388-478-0065, filed 7/14/05, effective 8/14/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0065, 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, § 388-478-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710 and 388-508-0820.]

WAC 388-478-0070 Monthly income and countable resource standards for medically needy (MN). (1) Changes to the medically needy income level (MNIL) occur on January 1st of each calendar year. Current income standards can be found at http://www1.dshs.wa.gov/pdf/esa/manual/Standards_C_MedAsst_Chart.pdf.

(2) Medically needy standards for persons who meet institutional status requirements are in WAC 388-513-1395. The standard for a client who lives in an alternate living facility can be found in WAC 388-513-1305.

(3) Find the resource standards for institutional programs in WAC 388-513-1350. The institutional standard chart can be found at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(4) Countable resource standards for the MN program are:

(a) One person	$2,000
(b) A legally married couple	$3,000
(c) For each additional family member add	$50

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-500. 08-11-098, § 388-478-0070, filed 5/20/08, effective 6/20/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 06-06-013, § 388-478-0070, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-06-090, § 388-478-0070, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-

478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

WAC 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL). (1) Each year, the federal government publishes new federal poverty level (FPL) income standards in the Federal Register found at http://aspe.hhs.gov/poverty/index.shtml. The income standards for the following medical programs change on the first of April every year based on the new FPL:

(a) Pregnant women's program up to one hundred eighty-five percent of FPL;

(b) Children's healthcare programs up to two hundred percent of FPL;

(c) Healthcare for workers with disabilities (HWD) up to two hundred twenty percent of FPL; and

(d) Premium-based coverage under the children's healthcare programs over two hundred percent of FPL but not over two hundred fifty percent of FPL.

(2) The department uses the FPL income standards to determine:

(a) The mandatory or optional medicaid status of an individual; and

(b) Premium amount, if any, for a child.

(3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-478-0075, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). 06-16-026, § 388-478-0075, filed 7/24/06, effective 8/24/06. Statutory Authority: RCW 74.08.090, 74.09.415, 74.09.530 and 2005 c 279. 06-03-080, § 388-478-0075, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-17-157, § 388-478-0075, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050, and 74.09.530. 04-15-092, § 388-478-0075, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and 42 U.S.C. 9902(2). 03-15-088, § 388-478-0075, filed 7/17/03, effective 7/17/03. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-478-0075, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.500, 74.09.510, and Section 1902 (a)(10)(A)(ii)(XV) and (XVI) of the Social Security Act. 02-07-090, § 388-478-0075, filed 3/19/02, effective 4/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0075, filed 8/30/01, effective 9/30/01; 00-17-085, § 388-478-0075, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0075, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0075, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

WAC 388-478-0080 Supplemental Security Income (SSI) standards; SSI-related categorically needy income level (CNIL); and countable resource standards. (1) The SSI payment standards, also known as the federal benefit rate (FBR), change each January 1.

(2) See WAC 388-478-0055 for the amount of the state supplemental payments (SSP) for SSI recipients.

(3) See WAC 388-513-1305 for standards of clients living in an alternate living facility.

(4) The SSI-related CNIL standards are the same as the SSI payment standards for single persons and couples. Those paying out shelter costs have a higher standard than people who have supplied shelter.

(5) The countable resource standards for SSI and SSI-related CN medical programs are:

(a) One person	$2,000
(b) A legally married couple	$3,000

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 08-11-098, § 388-478-0080, filed 5/20/08, effective 6/20/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 06-06-013, § 388-478-0080, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-06-090, § 388-478-0080, filed 3/1/05, effective 4/1/05; 04-16-107, § 388-478-0080, filed 8/3/04, effective 9/3/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. 02-10-116, § 388-478-0080, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). 01-12-073, § 388-478-0080, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0080, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0080, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0080, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0085 Medicare savings programs—Monthly income standards. (1) The income standards for medicare savings programs change each year based on the federal poverty level (FPL) published yearly by the federal government in the Federal Register at http://aspe.hhs.gov/poverty/index.shtml. The qualified medicare beneficiary (QMB) program income standard is up to one hundred percent of the FPL.

(2) The specified low-income medicare beneficiary (SLMB) program income standard is over one hundred percent of FPL, but not more than one hundred twenty percent of FPL.

(3) The qualified individual (QI-1) program income standard is over one hundred twenty percent of FPL, but not more than one hundred thirty-five percent of FPL.

(4) The qualified disabled working individual (QDWI) program income standard is two hundred percent of FPL.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). 06-16-026, § 388-478-0085, filed 7/24/06, effective 8/24/06; 05-17-157, § 388-478-0085, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 04-17-076, § 388-478-0085, filed 8/13/04, effective 9/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0085, filed 8/30/01, effective 9/30/01; 00-17-085, § 388-478-0085, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0085, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-480 WAC
STRIKERS

WAC

WAC 388-480-0001 Does being on strike impact my eligibility for the Washington Basic Food program? (1) A strike is a work stoppage, slowdown or other interruption of work caused by employees. This includes when a stoppage

happens because a collective bargaining agreement has expired.

(2) We do not consider you to be on strike if you:

(a) Are locked out by your employer;

(b) Do not have work available as a result of striking employees;

(c) Are not a member of the bargaining unit on strike and you fear someone may physically hurt you if you cross a picket line; or

(d) Would have been exempt from work registration under WAC 388-444-0015 the day before the strike for any reason other than being employed at least thirty hours per week.

(3) If a person in your assistance unit (AU) is a striker, your AU is not eligible for Basic Food unless:

(a) Your AU met all income requirements the day before the strike; and

(b) You meet all other requirements of the Basic Food program as described in WAC 388-400-0040.

(4) If someone in your AU is on strike, your AU cannot receive a higher amount of Basic Food benefits solely because the person receives less income as a direct result of being on strike. We count the larger of the two following amounts to determine if your AU is eligible and calculate your benefits:

(a) The striker's income before they went on strike; or

(b) The striker's current income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.-510. 03-22-037, § 388-480-0001, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.-510. 00-05-007, § 388-480-0001, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-480-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-482 WAC
STUDENT STATUS

WAC

WAC 388-482-0005 How does being a student impact my eligibility for the Washington Basic Food program? (1) For Basic Food, we consider you a student if you are:

(a) Age eighteen through forty-nine;

(b) Physically and mentally able to work; and

(c) Enrolled in an institution of higher education at least half-time as defined by the institution.

(2) An institution of higher education is:

(a) Any educational institution that requires a high school diploma or general education development certificate (GED);

(b) A business, trade, or vocational that requires a high school diploma or GED; or

(c) A two-year or four-year college or university that offers a degree but does not require a high school diploma or GED.

(3) If you are a student, you must meet one of the following conditions to be eligible for Basic Food:

(a) Have paid employment of twenty hours per week.

(b) Be self-employed, work, and earn at least the amount you would earn working twenty hours at the federal minimum wage;

(c) Be participating in a state or federal work study program at the time you applied for Basic Food benefits. For the purpose of being eligible for Basic Food, work study is:

(i) Working and receiving money from the work study program; and

(ii) Not turning down a work assignment.

(d) Be responsible for more than half the care of a dependent person in your assistance unit (AU) who is age five or younger;

(e) Be responsible for more than half the care of a dependent person in your AU who is between age six and eleven if we have determined that there is not adequate child care available during the school year to allow you to:

(i) Attend class and satisfy the twenty-hour work requirement; or

(ii) Take part in a work study program.

(f) Be a single parent responsible for the care of your natural, step, or adopted child who is eleven or younger;

(g) Be an adult who has the parental responsibility of a child who is age eleven or younger if none of the following people live in the home:

(i) The child's parents; or

(ii) Your spouse.

(h) Participate in the WorkFirst program under WAC 388-310-0200;

(i) Receive TANF or SFA benefits;

(j) Attend an institution of higher education through:

(i) The Workforce Investment Act (WIA);

(ii) The food stamp employment and training program under chapter 388-444 WAC;

(iii) An approved state or local employment and training program; or

(iv) Section 236 of the Trade Act of 1974.

(4) If you are a student and the only reason you are eligible for Basic Food is because you participate in work study, you are only eligible while you work and receive money from work study. If your work study stops during the summer months, you must meet another condition to be an eligible student during this period.

(5) If you are a student, your status as a student:

(a) Begins the first day of the school term; and

(b) Continues through vacations. This includes the summer break if you plan to return to school for the next term.

(6) We do not consider you a student if you:

(a) Graduate;

(b) Are suspended or expelled;

(c) Drop out; or

(d) Do not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.-510. 03-22-037, § 388-482-0005, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-482-0005, 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, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC
TANF/SFA FIVE YEAR TIME LIMIT

WAC

WAC 388-484-0005 There is a five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance. (1) **What is the sixty-month time limit?**

(a) You can receive cash assistance for temporary assistance for needy families (TANF), state family assistance (SFA), and general assistance for pregnant women (GA-S) for a lifetime limit of sixty months. The time limit applies to cash assistance provided by any combination of these programs, and whether or not it was received in consecutive months.

(b) If you receive cash assistance for part of the month, it counts as a whole month against the time limit.

(c) If you have received cash assistance from another state on or after August 1, 1997, and it was paid for with federal TANF funds, those months will count against your time limit.

(d) The time limit does not apply to diversion cash assistance, support services, food assistance or medicaid.

(2) **When did the sixty-month time limit go into effect?**

The sixty-month time limit applies to cash assistance received on or after August 1, 1997 for TANF and SFA. Although the GA-S program no longer exists, the time limit applies to GA-S cash assistance received from May 1, 1999 through July 31, 1999.

(3) **Does the time limit apply to me?**

The sixty-month time limit applies to you for any month in which you are a parent or other relative as defined in WAC 388-454-0010, or a minor parent emancipated through court order or marriage.

(4) **Do any exceptions to the time limits apply to me?**

The department does not count months of assistance towards the sixty-month time limit if you are:

(a) An adult caretaker, as described in WAC 388-454-0005 through 388-454-0010, who is not a member of the assistance unit and you are receiving cash assistance on behalf of a child;

(b) An unemancipated pregnant or parenting minor living in a department approved living arrangement as defined by WAC 388-486-0005; or

(c) An American Indian or Native Alaskan adult and you are living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village and you are receiving TANF, SFA, or GA-S cash assistance during a period when at least fifty percent of the adults living in Indian country or in the village were not employed. See WAC 388-484-0010.

(5) **What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?**

Once any adult or emancipated minor in the assistance unit has received sixty months of cash assistance, the entire assistance unit becomes ineligible for TANF or SFA cash assistance, unless you are eligible for an extended period of cash assistance called a TANF/SFA time limit extension under WAC 388-484-0006.

(6) **What can I do if I disagree with how the department has counted my months of cash assistance?**

(a) If you disagree with how we counted your months of cash assistance, you may ask for a hearing within ninety days of the date we sent you a letter telling you how many months we are counting.

(b) You will get continued benefits (the amount you were getting before the change) if:

(i) You have used all sixty months of benefits according to our records; and

(ii) You ask for a hearing within the ten-day notice period, as described in chapter 388-458 WAC.

(c) If you get continued benefits and the administrative law judge (ALJ) agrees with our decision, you may have to pay back the continued benefits after the hearing, as described in chapter 388-410 WAC.

(7) **Does the department ever change the number of months that count against my time limit?**

We change the number of months we count in the following situations:

(a) You repay an overpayment for a month where you received benefits but were not eligible for any of the benefits you received. We subtract one month for each month that you completely repay. If you were eligible for some of the benefits you received, we still count that month against your time limit.

(b) We did not close your grant on time when the division of child support (DCS) collected money for you that was over your grant amount two months in a row, as described in WAC 388-422-0030.

(c) An ALJ decides at a fair hearing that we should change the number of months we count.

(d) You start getting worker's compensation payments from the department of labor and industries (L&I) and your L&I benefits have been reduced by the payments we made to you.

(e) You participated in the excess real property (ERP) program in order to get assistance and we collected the funds when your property sold.

(f) Another state gave us incorrect information about the number of months you got cash assistance from them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0005, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-484-0005, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 03-06-046, § 388-484-0005, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0005, filed 5/31/02, effective 6/1/02. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0005, filed 1/26/01, effective 2/1/01. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-484-0005, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-484-0006 TANF/SFA time limit extensions. (1) **What happens after I receive sixty or more months of TANF/SFA cash assistance?**

After you receive sixty or more months of TANF/SFA cash assistance, you may qualify for additional months of cash assistance. We call these additional months of TANF/SFA cash assistance a TANF/SFA time limit extension.

(2) **Who is eligible for a TANF/SFA time limit extension?**

You are eligible for a TANF/SFA time limit extension if you are on TANF or otherwise eligible for TANF and:

(a) You qualify for one of the exemptions listed in WAC 388-310-0350; or

(b) You:

(i) Are participating satisfactorily in the WorkFirst program (see chapter 388-310 WAC for a description of WorkFirst participation requirements); or

(ii) Meet the family violence option criteria in WAC 388-61-001 and are participating satisfactorily in specialized activities listed in your individual responsibility plan.

(c) You have a temporary situation that prevents you from working or looking for a job. (For example, you may be unable to look for a job while you have health problems or if you are dealing with family violence.) You will receive a time-limited extension if you are participating in activities included in your individual responsibility plan to help your situation.

(d) You are in sanction, but you will be subject to the sanction rules described in WAC 388-310-1600.

(3) **Who reviews and approves an extension?**

(a) Your case manager or social worker will review your case and determine which extension type will be approved.

(b) This review will not happen until after you have received at least fifty-two months of assistance but before you reach your time limit.

(c) Before you reach your time limit, the department will send you a notice that tells you whether your extension was approved and how to request a fair hearing if you disagree with the decision.

(4) **Do my WorkFirst participation requirements change if I receive a TANF/SFA time limit extension?**

Your participation requirements do not change. You must still meet all of the WorkFirst participation requirements listed in chapter 388-310 WAC while you receive a TANF/SFA time limit extension.

(5) **Do my benefits change if I receive a TANF/SFA time limit extension?**

(a) You are still a TANF/SFA recipient and your cash assistance, services, or supports will not change as long as you continue to meet all other TANF/SFA eligibility requirements.

(b) During the TANF/SFA time limit extension, you must continue to meet all other TANF/SFA eligibility requirements. If you no longer meet TANF/SFA eligibility criteria during your extension, your benefits will end.

(6) **What happens if I stop participating in WorkFirst activities as required during a TANF/SFA time limit extension?**

If you do not participate in the WorkFirst activities required in your individual responsibility plan, and you do not have a good reason under WAC 388-310-1600(4), the department will follow the sanction rules in WAC 388-310-1600.

(7) **How long will a TANF/SFA time limit extension last?**

(a) We will review your TANF/SFA time limit extension and your case periodically for changes in family circumstances:

(i) If you are extended under WAC 388-484-0006 (2)(a) then we will review your extension at least every twelve months;

(ii) If you are extended under WAC 388-484-0006 (2)(b) then we will review your extension at least every six months;

(iii) If you are extended under WAC 388-484-0006 (2)(c) or (d) then we will review your extension at least every twelve months.

(b) Your TANF/SFA time limit extension may be renewed for as long as you continue to meet the criteria to qualify.

(c) If during the extension period we get proof that your circumstances have changed, we may review your case and change the type of TANF/SFA time limit extension.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0006, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 03-24-057, § 388-484-0006, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-12-068, § 388-484-0006, filed 5/31/02, effective 6/1/02.]

WAC 388-484-0010 How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to American Indians or Alaskan Natives living in Indian country? (1) **If you are American Indian or Alaskan Native, time limits on temporary assistance for needy families (TANF), state family assistance (SFA) and general assistance for pregnant women (from May 1, 1999 to July 31, 1999) do not count under certain circumstances.**

If you are an American Indian or Alaskan Native parent or other relative as defined by WAC 388-454-0010, months of cash assistance do not count against the sixty-month lifetime limit if you live in Indian country or an Alaskan Native village where at least fifty percent of Indian adults are not employed.

(2) **Do time limits on cash assistance apply if I am not an American Indian or Alaskan Native but I am the parent or other relative of an American Indian or Alaskan Native child?**

If you are a non-American Indian or non-Alaskan Native parent or other relative, as defined by WAC 388-454-0010, of an American Indian or Alaskan Native child or children living in a qualifying area of Indian country, your months on assistance will count against your lifetime limit. You may, however, receive more than sixty months of assistance under hardship criteria to be developed by the department.

(3) **Where must I live to qualify for the Indian country exemption to time limits?**

To qualify for this exemption to TANF time limits, you must live in "Indian country." The department uses the "Indian country" definition in federal law at 18 U.S.C. 1151. Indian country is defined as reservations, dependent Indian communities, and allotments. Dependent Indian communities must be set aside by the federal government for the use of Indians and be under federal superintendence. Near reserva-

tion areas (areas or communities adjacent or contiguous to reservations) are not considered Indian country for purposes of this exemption.

(4) **Can I live on the reservation or Indian country belonging to a tribe other than my own to qualify for this time limit exemption?**

Yes. You do not need to be an American Indian or Alaskan Native of the same tribe as the reservation or other area of Indian country on which you reside.

(5) **How does the department determine if at least fifty percent of adults living in Indian country are not employed?**

The department uses the most current biennial *Indian Service Population and Labor Force Estimates Report* published by the Bureau of Indian Affairs (BIA), or any successor report, as the default data source to determine if the not employed rates for areas of Indian country are at least fifty percent.

(6) **What if a tribe disagrees with the not employed rate published in the BIA Indian Service Population and Labor Force Estimates Report?**

A tribe may provide alternative data, based on similar periods to the *Indian Service Population and Labor Force Estimates Report*, to demonstrate that the not employed rate is at least fifty percent.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0010, filed 1/26/01, effective 2/1/01.]

Chapter 388-486 WAC
TEEN PARENTS

WAC

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or GA-S unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-486-0010 Unmarried pregnant or parenting minors—Required school attendance. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) To be eligible for TANF or SFA, an unmarried pregnant or parenting minor who has not completed high school or a general education development (GED) certificate program must participate in educational activities leading to the attainment of a high school diploma or GED.

(3) The minor must meet the standard for satisfactory attendance set by the school or program in which the minor is enrolled.

(4) An unmarried minor is exempt from this rule if the minor has:

(a) Been emancipated by a court; or

(b) A child who is less than twelve weeks old.

(5) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-488 WAC
TRANSFER OF PROPERTY

WAC

WAC 388-488-0005 Transfer of property to qualify for cash assistance. This rule applies to cash assistance programs only and does not affect medicaid eligibility for a person who is not institutionalized. For transfer of property for institutional medical see WAC 388-513-1365.

(1) An assistance unit is disqualified from receiving benefits when it transferred or transfers real or personal property for less than its market value in an attempt to qualify for benefits:

(a) Two years prior to the date of application;

(b) During the application process; or

(c) Anytime while receiving benefits.

(2) When an assistance unit transferred property for less than its fair market value in an attempt to qualify for benefits, the disqualification period:

(a) For applicants, begins the first day of the month the property was transferred.

(b) For recipients, begins the first day of the month after the month the property was transferred.

(3) To determine the number of months an assistance unit will be disqualified, divide the uncompensated resource value of the transferred property by the state gross median income. The uncompensated resource value is the equity value minus the amount the client received when transferring a resource.

(4) An assistance unit can provide evidence to clarify the reasons for transferring the property when the department presumes that the assistance unit transferred the property in an attempt to qualify for benefits.

(5) The benefits received by an assistance unit are not affected by the transfer of separate property of a spouse who is not a member of the assistance unit.

(6) An assistance unit's disqualification period is reduced when the client:

(a) Verifies undue hardship will exist if the benefits are denied such as an eviction;

(b) Secures a return of some or all of the transferred property or the equivalent value of the transferred property;

(c) Verifies an unforeseen change in circumstances such as extensive hospitalization; or

(d) Is responsible for and can verify medical expenses.

(7) When a disqualification period has been adjusted and the client is otherwise eligible, benefits will be authorized. Any benefits authorized because of the reason(s) in subsection (6) of this section, are not considered an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-518-1820.]

WAC 388-488-0010 Transfer of property to qualify for food assistance. (1) An assistance unit is disqualified from the program when it transfers a resource to qualify or attempt to qualify for benefits:

(a) Three months prior to the month of application; or

(b) Beginning the month the household is approved for benefits.

(2) The length of disqualification depends on the dollar amount the household is over the resource limit. The countable resources transferred are added to the assistance unit's other countable resources. This total is compared to the resource limit. The amount in excess of the resource limit is located on the chart below to determine the length of the disqualification period.

Amount Over the Resource Limit	Disqualification Period
$ 0 - $ 249.99	1 month
250 - 999.99	3 months
1,000 - 2,999.99	6 months
3,000 - 4,999.99	9 months
5,000 and over	12 months

(3) The disqualification period begins:

(a) For applicants, the month of application; or

(b) For recipients, the first of the month after the advance notice period expires.

(4) An assistance unit will not be disqualified for transferring the following:

(a) Excluded resources that do not affect eligibility;

(b) Resources sold or traded at or near fair market value (FMV);

(c) Resources transferred between assistance unit members of the same household including ineligible household members; and

(d) Resources transferred for reasons other than to qualify for benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-489 WAC
TRANSITIONAL FOOD ASSISTANCE

WAC

WAC 388-489-0005 Who is eligible for transitional food assistance? If your family stops receiving temporary assistance for needy families cash benefits, including benefits from a tribal program, you will be eligible for transitional food assistance for up to five months if you meet all the following eligibility requirements:

(1) Your family was receiving Basic Food at the time we determined you were no longer eligible for temporary assistance for needy families;

(2) After your family stops receiving temporary assistance for needy families, no other member of your Basic Food assistance unit continues to receive temporary assistance for needy families;

(3) Your family did not move out of the state of Washington (WAC 388-468-0005);

(4) Your family was not in sanction status at the time your temporary assistance for needy families grant ended. Sanction status means:

(a) We reduced or stopped your family's temporary assistance for needy families grant payment because a family member is not:

(i) Meeting WorkFirst program requirements (WAC 388-310-1600); or

(ii) Cooperating with the division of child support (WAC 388-422-0100); or

(b) We decided that a member of your family was not eligible for temporary assistance for needy families because the member:

(i) Failed to meet teen parent living arrangement (WAC 388-486-0005) or teen parent school attendance requirements (WAC 388-410-0010); or

(ii) Was convicted of unlawful practices (WAC 388-446-0005) or for receiving temporary assistance for needy families in two or more states at the same time (WAC 388-446-0010); or

(c) If you are receiving temporary assistance for needy families benefits from a tribal program, your family's grant is reduced or stopped for a reason that is the same as one of the reasons listed in (4)(a) or (4)(b) of this section.

(5) At the time your family's temporary assistance for needy families grant ended, your Basic Food assistance unit did not become ineligible because:

(a) You were applying for recertification of your Basic Food benefits and refused to cooperate with the application process; or

(b) All members are ineligible for Basic Food for the reasons stated in WAC 388-489-0025(3).

(6) There is no limit to the number of times your family may leave temporary assistance for needy families and receive transitional food assistance.

[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, § 388-489-0005, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0010 How is my transitional food assistance benefit calculated? (1) We base your transitional food assistance benefit amount on the regular monthly benefit allotment issued to your Basic Food assistance unit for the last month your family received temporary assistance for needy families. We will not count your last temporary assistance for needy families grant payment when we calculate your transitional food assistance benefit amount. For example:

(a) If your Basic Food assistance unit's only income was temporary assistance for needy families, the transitional food assistance benefit will be the amount your household would have received if you had no income.

(b) If your Basic Food benefit was calculated using temporary assistance for needy families plus income from another source, we will count only the income from the other source when calculating the transitional food assistance amount.

(2) We will adjust your transitional food assistance benefits if:

(a) Someone who gets transitional food assistance with you leaves your assistance unit and is found eligible to receive Basic Food in another assistance unit. We will reduce your transitional food assistance based on the number of persons who left your assistance unit and become eligible in another Basic Food assistance unit.

(b) A change to the maximum allotment for Basic Food under WAC 388-478-0060 results in an increase in benefits for Basic Food assistance units.

(c) You got an overpayment of Basic Food benefits and we need to adjust the amount we deduct from your monthly benefits to repay the overpayment as required in WAC 388-410-0033. This includes:

(i) Starting a new monthly deduction;

(ii) Changing the amount of the monthly deduction; and

(iii) Ending the monthly deduction when the amount you owe has been paid off.

[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, § 388-489-0010, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0015 How long will my family receive transitional food assistance? If your Basic Food assistance unit is eligible for transitional food assistance according to WAC 388-489-0005, you will receive transitional food assistance for up to five months after your family leaves temporary assistance for needy families.

(1) If you stopped getting temporary assistance for needy families from the department, you are eligible for transitional benefits beginning the month after your family received their last grant.

(2) If you stopped receiving tribal TANF benefits, you are eligible for transitional benefits:

(a) With the next monthly issuance after we update your case to show you no longer have tribal TANF income, if the tribal TANF end date is the end of the current month or the end of a prior month; or

(b) On the first of the month following the tribal TANF end date, if the tribal TANF end date is the end of a future month.

(3) If necessary, we will extend or shorten your Basic Food assistance unit's current certification period to match the five-month transition period.

(4) You may choose to end your five-month transition period early by submitting an application for regular Basic Food under WAC 388-489-0020 or by asking us to terminate your benefits.

(5) We send you a notice before the end of your five-month transition period so you can reapply for regular Basic Food benefits and continue to receive benefits without interruption as described in WAC 388-434-0010.

(6) We may terminate your transitional food assistance early for the reasons stated in WAC 388-489-0025.

[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, § 388-489-0015, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0020 Am I required to report changes in my household's circumstances while on transitional food assistance? (1) If you only receive transitional food assistance, you are not required to report any changes in your household circumstances.

(2) If you receive benefits from another cash or medical assistance program, you must meet the reporting requirements for the other program as required by WAC 388-418-0005. Except for changes listed under WAC 388-489-0025, the changes you report for the other program will not affect your family's eligibility for transitional food assistance.

(3) If you family experiences a change in circumstances during your five-month transition period, and you think that you may be eligible for more food assistance, you may submit an application for the regular Basic Food program. Examples of such changes include the loss of income by a person who gets transitional food assistance with you or adding a new person to your household.

(a) If you submit a new application, we will determine your eligibility for Basic Food and allow you to choose if you want to remain on transitional food assistance or receive regular Basic Food benefits.

(b) If you choose to go back on Basic Food and are found eligible, we will start your new benefit amount on the first day of the month after we receive your application for Basic Food. If you have already received transitional food assistance for this month and are eligible for more assistance on the Basic Food program, we will pay you the additional amount.

[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, § 388-489-0020, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0025 Can my transitional food assistance benefits end before the end of my five-month transition period? Your transitional food assistance benefits will end early if:

(1) Someone who gets transitional food assistance with you applies and is approved for temporary assistance for needy families while still living in your home. You may reapply to have your eligibility for Basic Food determined;

(2) We learn that you and your family are no longer residing in the state of Washington; or

(3) **All members** of your household are ineligible to get Basic Food for any of the following reasons:

(a) Refusal to cooperate with quality assurance (WAC 388-464-0001);

(b) Transfer of property to qualify for Basic Food assistance (WAC 388-488-0010);

(c) Intentional program violation (WAC 388-466-0015 and 388-446-0020);

(d) Fleeing felon or violating a condition of probation or parole (WAC 388-442-0010);

(e) Alien status (WAC 388-424-0020 and 388-424-0025);

(f) Employment and training requirements (WAC 388-444-0055 and 388-444-0075);

(g) Work requirements for able-bodied adults without dependents (WAC 388-444-0030);

(h) Student status (WAC 388-482-0005);

(i) Living in an institution where residents are not eligible for Basic Food (WAC 388-408-0040); or

(j) Deceased.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 09-01-049, § 388-489-0025, filed 12/10/08, effective 1/10/09. 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, § 388-489-0025, filed 9/16/05, effective 11/1/05.]

Chapter 388-490 WAC
VERIFICATION

WAC

WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food. This rule applies to cash, medical, and Basic Food.

(1) When you first apply for benefits, the department may require you to provide proof of things that help us decide if you are eligible for benefits. This is also called "verification." The types of things that need to be proven are different for each program.

(2) After that, we will ask you to give us proof when:

(a) You report a change;

(b) We find out that your circumstances have changed; or

(c) The information we have is questionable, confusing, or outdated.

(3) Whenever we ask for proof, we will give you a notice as described in WAC 388-458-0020.

(4) You must give us the proof within the time limits described in:

(a) WAC 388-406-0030 if you are applying for benefits; and

(b) WAC 388-458-0020 if you currently receive benefits.

(5) We will accept any proof that you can easily get when it reasonably supports your statement or circumstances. The proof you give to us must:

(a) Clearly relate to what you are trying to prove;

(b) Be from a reliable source; and

(c) Be accurate, complete, and consistent.

(6) We cannot make you give us a specific type or form of proof.

(7) If the only type of proof that you can get costs money, we will pay for it.

(8) If the proof that you give to us is questionable or confusing, we may:

(a) Ask you to give us more proof, which may include providing a collateral statement. A "collateral statement" is from someone outside of your residence who knows your situation;

(b) Schedule a visit to come to your home and verify your circumstances; or

(c) Send an investigator from the Division of Fraud Investigations (DFI) to make an unannounced visit to your home to verify your circumstances.

(9) By signing the application, eligibility review, or change of circumstances form, you give us permission to contact other people, agencies, or institutions.

(10) If you do not give us all of the proof that we have asked for, we will determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we will deny or stop your benefits.

(11) For all medicaid programs, you must provide proof of citizenship and identity as specified at Section 6036 of the Deficit Reduction Act of 2005 (PL 106-171 amending USC 1396b). Exempt from this requirement are recipients of:

(a) SSI cash benefits; or

(b) Medicare.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.530, and Public Law 109-171, Section 6036. 07-02-066, § 388-490-0005, filed 12/29/06, effective 1/29/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, and 74.04.510. 03-21-029, § 388-490-0005, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 00-08-091, § 388-490-0005, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-490-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0460.]

Chapter 388-492 WAC

WASHINGTON COMBINED APPLICATION PROJECT

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-492-0010 Washington state combined application program (WASHCAP) definitions. [Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0010, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0010, filed 10/16/01, effective 12/1/01.] Repealed by 04-23-026, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090.

WAC 388-492-0020 What are WASHCAP food benefits? WASHCAP means the Washington State Combined Application program.

(1) WASHCAP is a simplified food benefits program for certain Supplemental Security Income (SSI) recipients. Unless specifically stated in this WAC chapter, WASHCAP food benefits follow all the program requirements of the Basic Food program as described under WAC 388-400-0040.

(2) Social Security Administration (SSA) asks you if you want to get food benefits when you apply for SSI in Washington state.

(3) If you meet the requirements of WAC 388-492-0030, you will get WASHCAP food benefits unless you can choose Basic Food benefits under WAC 388-492-0040.

(4) If you are eligible for WASHCAP food benefits under WAC 388-492-0030, SSA electronically sends us the information we need to open your WASHCAP food benefits.

(5) WASHCAP food benefits begin the first month after the month you are eligible for ongoing SSI.

(6) You do not have to go to your local community services office (CSO) to apply for WASHCAP.

(7) If you want Basic Food benefits before WASHCAP food benefits begin, you can apply at your local CSO, home and community services office (HCS), or SSA.

(8) While you get WASHCAP food benefits, you must report all changes to SSA.

(9) SSA shares the changes you report to them with your WASHCAP worker.

(10) You do not have to report changes to your WASHCAP worker. See WAC 388-492-0080.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0020, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0020, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0020, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0030 Who can get WASHCAP? (1) You can get WASHCAP food benefits if:

(a) You are eligible to receive federal SSI benefits; and

(b) You are eighteen years of age or older; and

(c) You live alone, or SSA considers you as a single household; or

(d) You live with others but buy and cook your food separately from them; and

(e) You do not have earned income when you apply for SSI; or

(f) You already get WASHCAP food benefits and become employed and receive earned income for less than three consecutive months; or

(g) You already get WASHCAP and move to an institution for ninety days or less.

(2) You are not eligible for WASHCAP food benefits if:

(a) You live in an institution;

(b) You are under age eighteen;

(c) You live with your spouse;

(d) You are under age twenty-two and you live with your parent(s) who are getting Basic Food benefits;

(e) You begin working after you have been approved for WASHCAP and have earned income for more than three consecutive months;

(f) You live with others and do not buy and cook your food separately from them; or

(g) You are ineligible for Basic Food benefits under WAC 388-400-0040 (13)(b) and (e).

(3) We accept SSA information about your WASHCAP eligibility unless you prove the information is not accurate.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0030, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0030, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0030, filed 10/16/01, effective 12/1/01.]

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 388-492-0050 How do I apply for WASHCAP? (1) You apply for WASHCAP food benefits at Social Security Administration (SSA) when you apply for Supplemental Security Income (SSI).

(2) If you want food benefits, your SSA worker will ask you WASHCAP food eligibility questions when you have your SSI interview.

(3) If you are eligible for WASHCAP food benefits, your benefits will start the first of the month after the month you are eligible for ongoing SSI benefits.

(4) If you need food benefits in five days or less, you must apply for expedited services at:

(a) Your local community services office (CSO);

(b) Your local home and community services office (HCS) if you get long-term care services; or

(c) The SSA office if you give them an application for Basic Food expedited services when you apply for SSI. SSA forwards the Basic Food application to the local CSO to process.

(5) If you want Basic Food benefits before you get SSI, you must apply at:

(a) SSA if you give them a Basic Food application when you apply for SSI;

(b) Your local CSO; or

(c) Your local HCS office if you get long-term care services.

(6) If you already receive SSI and want WASHCAP food benefits, you can apply at:

(a) Your SSA office;

(b) Your local CSO;

(c) Your local HCS office if you get long-term care services.

(7) If you get Basic Food benefits, these benefits will continue:

(a) Through the end of your certification period; or

(b) Through the month before your WASHCAP food benefits start.

(8) If your Basic Food benefits end before you are eligible for WASHCAP food benefits, you must reapply to continue these benefits.

(9) If you get Basic Food benefits and you become eligible for WASHCAP food benefits, we will automatically change your Basic Food benefits to WASHCAP food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0050, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0060 How do I get my WASHCAP food benefits? (1) If you are eligible for WASHCAP, you will get your food benefits through electronic benefits transfer (EBT).

(2) The department issues your EBT food benefits according to WAC 388-412-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0060, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0060, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0060, 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 forty-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 eighty-four dollars or more a month for shelter, we use three hundred seventy-nine dollars as your shelter cost; or

(b) Less than two hundred eighty-four dollars for shelter, we use one hundred eighty-two 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 the minimum monthly benefit for Basic Food under WAC 388-412-0015.

[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. 08-21-106, § 388-492-0070, filed 10/16/08,

effective 11/16/08. 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.]

WAC 388-492-0080 Where do I report changes? (1) You report all changes to Social Security Administration (SSA) according to their reporting requirements. Social Security reports these changes to your WASHCAP worker.

(2) SSA will not accept or report shelter costs changes to WASHCAP until SSA does its redetermination.

(3) You do not have to report any changes to your WASHCAP worker.

(4) You can choose to report the following changes to your WASHCAP worker to see if you will get more food benefits.

(a) A change in your address;

(b) An increase in your shelter costs; or

(c) An increase in your out-of-pocket medical expenses.

(5) If changes are reported to DSHS, proof may be required.

(6) If you report a change that could increase the amount of your food benefits, we will not increase the benefit amount if we have asked for proof and it has not been provided.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0080, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0080, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0080, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0090 How often do my WASHCAP food benefits need to be reviewed? (1) Your eligibility for WASHCAP food benefits must be reviewed at least every thirty-six months.

(2) Your certification period is the amount of time your assistance unit is eligible for WASHCAP food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and FNS waiver. 08-20-098, § 388-492-0090, filed 9/30/08, effective 11/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0090, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0090, filed 7/22/02, effective 9/1/02;01-21-058, § 388-492-0090, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0100 How is my eligibility for WASHCAP food benefits reviewed? (1) If Social Security Administration (SSA) reviews your Supplemental Security Income (SSI) eligibility, they will also complete your review for WASHCAP. SSA sends us this information electronically and we will automatically extend your WASHCAP certification period.

(2) If SSA does not review your SSI eligibility, we will mail you a one-page application two months before your WASHCAP benefits end. You must complete and return this application to the WASHCAP unit or your local home and community services office (HCS).

(3) We do WASHCAP reviews by mail. If you bring your WASHCAP application to the local office, we will process the application as follows:

(a) If you get long-term care services, your local HCS office will process your application; or

(b) If you do not get long-term care services, the local office will forward your application to the WASHCAP central unit.

(4) If we get your completed one-page application after your WASHCAP food benefits end, we will reopen your benefits back to the first of the month if:

(a) We get your application form within thirty days from the end of your certification period; and

(b) You are still eligible for WASHCAP food benefits.

(5) If we get your completed one-page application form more than thirty days after your benefits end, your WASHCAP food benefits open the first of the next month after you turn in your application and SSA shows you are eligible for WASHCAP in their system.

(6) If your application is not complete, we will return it to you to complete.

(7) If you want Basic Food benefits while you are waiting for WASHCAP food benefits, you must apply for these benefits at the local CSO or HCS office.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0100, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0100, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0100, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0110 What happens if my WASHCAP food benefits end? (1) If your WASHCAP food benefits end because you did not have the review required under WAC 388-492-0100, you must finish the required review or apply for Basic Food benefits at:

(a) Your local community services office (CSO); or

(b) Your home and community services (HCS) office.

(2) If your WASHCAP benefits end because you are disqualified under WAC 388-400-0040 (13)(b) or (e), you are not eligible for Basic Food benefits and:

(a) If you get medical assistance, we will send your medical assistance case to your local office;

(b) If you are a HCS client, your medical case will remain at HCS.

(3) If your WASHCAP benefits end for any other reason:

(a) We will send you an application for Basic Food benefits along with:

(i) Information about what you must verify in order to get benefits; and

(ii) The address of your local CSO. If you are an HCS client, your case will remain at your HCS office.

(b) For the local CSO to decide if you are eligible for Basic Food benefits, you must:

(i) Finish the application process for Basic Food benefits under chapter 388-406 WAC; and

(ii) Have an interview for Basic Food benefits under WAC 388-452-0005.

(c) If you get medical assistance, we will send your medical case to the local CSO unless you are an HCS client;

(d) If your WASHCAP benefits closed because SSA ended your SSI, you will still receive the same medical benefits until we decide what medical program you are eligible for under WAC 388-418-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0110, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0110, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0110, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0120 What happens to my WASHCAP benefits if I am disqualified? (1) If you are disqualified from receiving SSI for any reason, you will not be able to get WASHCAP benefits. See WAC 388-492-0030, Who can get WASHCAP?

(2) If you are disqualified from receiving Basic Food for any reason, you will not get WASHCAP food benefits. This includes clients who:

(a) Are ineligible under WAC 388-400-0040 (13)(b) and (e) and 388-442-0010; or

(b) Did not cooperate with quality assurance as required under WAC 388-464-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0120, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0120, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0120, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0130 What can I do if I disagree with a decision the department made about my WASHCAP benefits? (1) If you disagree with a decision about your benefits, you may ask for a fair hearing.

(2) You can ask for a hearing by contacting the WASHCAP central unit, home and community service office or any responsible department or office of administrative hearings employee.

(3) See chapter 388-02 WAC for information on the fair hearing process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0130, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0130, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0130, filed 10/16/01, effective 12/1/01.]

Chapter 388-500 WAC
MEDICAL DEFINITIONS

WAC

WAC 388-500-0005 Medical definitions. Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives:

*A federal cash Title XVI benefit; and/or

*State supplement under Title XVI; or

*Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means:

*An organization contracting with the federal government to process claims under Part B of medicare; or

*A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen:

*Whose family income does not exceed one hundred percent of the federal poverty level; and

*Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-medicare" means an initial specified amount that is the responsibility of the client.

***"Part A of medicare-inpatient hospital deductible"** means an initial amount of the medical care cost in each benefit period which medicare does not pay.

***"Part B of medicare-physician deductible"** means an initial amount of medicare Part B covered expenses in each calendar year which medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

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

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

*Placing the patient's health in serious jeopardy;

*Serious impairment to bodily functions; or

*Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement" 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 medically indigent program.

"Essential spouse" see **"spouse."**

"Extended care patient" means a recently hospitalized medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means:

*A noninstitutionalized person who meets all current requirements for medicaid eligibility except the criteria for blindness or disability; and

*Was eligible for medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the medicaid plan in December 1973; and

*An institutionalized person who was eligible for medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the medicaid program and for each consecutive month after December 1973 who:

*Continues to meet the requirements for medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

*Remains institutionalized.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see **"EPSDT."**

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

***"Earned income"** means gross wages for services rendered and/or net earnings from self-employment.

***"Unearned income"** means all other income.

"Institution" means an establishment which furnishes food, shelter, medically related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

***"Institution-public"** means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

***"Institution for mental diseases"** means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

***"Institution for the mentally retarded or a person with related conditions"** means an institution that:

*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

***"Institution for tuberculosis"** means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

***"Medical institution"** means an institution:

*Organized to provide medical care, including nursing and convalescent care;

*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

*Authorized under state law to provide medical care; and

*Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for:

*Categorically needy program as defined in WAC 388-503-0310; or

*Medically needy program as defined in WAC 388-503-0320.

"Medical assistance." See **"medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

*__"Part A"__ covers the medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

*__"Part B"__ is the supplementary medical insurance benefit (SMIB) covering the medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

*Department certifies; and

*Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities:

*Are medically necessary;

*Meet professionally acceptable standards of health care; and

*Are appropriately provided in an outpatient or institutional setting for beneficiaries of medicare and clients of medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

*Artificially replace a missing portion of the body;

*Prevent or correct physical deformity or malfunction; or

*Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person:

*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

*Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

*If an individual can reduce a liquid asset to cash, it is a resource.

*If an individual cannot reduce an asset to cash, it is not considered an available resource.

*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spenddown" 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.

"Spouse" means:

*__"Community spouse"__ means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waivered program as described under chapter 388-515 WAC.

*__"Eligible spouse"__ means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

*__"Essential spouse"__ means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

*__"Ineligible spouse"__ means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

*__"Institutionalized spouse"__ means a married person in an institution or receiving services from a home or community-based waivered program.

*__"Nonapplying spouse"__ means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

*__"Mandatory state supplement"__ means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

*__"Optional state supplement"__ means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

*An intentional act or transfer; or

*Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-500-0005, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]-230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

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.

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-501-0105	Applicability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0105, filed 5/3/94, effective 6/3/94. Formerly WAC 388-80-002.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-501-0110	Purpose of the medical care program. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0110, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-81-005, 388-81-025, 388-99-005 and 388-100-005.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-501-0130	Administrative controls. [Statutory Authority: RCW 74.08.090 and 74.09.290. 96-06-041 (Order 3949), § 388-501-0130, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-015.] Repealed by 00-23-014, filed

	11/3/00, effective 12/4/00. Statutory Authority: RCW 74.08.090, 43.20B.675.
388-501-0140	Fraud. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0140, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-446-0001.
388-501-0150	Confidential records. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-035.] Repealed by 00-14-047, filed 6/30/00, effective 7/31/00.
388-501-0170	Third party resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0170, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-010 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0540.
388-501-0190	Maternity care distressed area. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0190, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-070.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-501-0300	Limits on scope of medical program services. [Statutory Authority: RCW 74.08.090. 01-12-072, § 388-501-0300, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, amended and recodified as § 388-501-0300, filed 11/13/00, effective 12/14/00. Statutory Authority: RCW 74.08.090. 93-16-037 (Order 3599), § 388-86-200, filed 7/28/93, effective 8/28/93; 93-11-086 (Order 3536), § 388-86-200, filed 5/19/93, effective 6/19/93.] Repealed by 06-24-036, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.

WAC 388-501-0050 Healthcare general coverage. The following rules, WAC 388-501-0050 through 388-501-0065, describe the healthcare services available to a client on a fee-for-service basis or as an enrollee in a managed care organization (MCO)(defined in WAC 388-538-050). Noncovered services are described in WAC 388-501-0070.

(1) Service categories listed in WAC 388-501-0060 do not represent a contract for services.

(2) The client must be eligible for the covered service on the date the service is performed or provided.

(3) The department pays only for medical or dental services, equipment, or supplies that are:

(a) Within the scope of the client's medical program;

(b) Covered - see subsection (5);

(c) Medically necessary;

(d) Ordered or prescribed by a healthcare provider meeting the requirements of chapter 388-502 WAC; and

(e) Furnished by a provider according to the requirements of chapter 388-502 WAC.

(4) The department's fee-for-service program pays only for services furnished by enrolled providers who meet the requirements of chapter 388-502 WAC.

(5) The department does not pay for any service, treatment, equipment, drug, or supply requiring prior authorization from the department, if prior authorization was not obtained before the service was provided.

(6) **Covered services**

(a) Covered services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the service for medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered services. Limitation extensions are authorized according to WAC 388-501-0169.

(7) **Noncovered services**

(a) The department does not pay for any service, equipment, or supply:

(i) That federal or state law or regulations prohibit the department from covering;

(ii) Listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) applies, a noncovered service, equipment, or supply will be evaluated according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.04.050 and 74.08.-090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0060 Healthcare coverage—Scope of covered categories of service. (1) This rule provides a list (see subsection (5)) of medical, dental, mental health, and substance abuse categories of service covered by the department under categorically needy (CN) medicaid, medically needy (MN) medicaid, Alien Emergency Medical (AEM), and medical care services (MCS) programs. MCS means the limited scope of care financed by state funds and provided to general assistance and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program clients.

(2) Not all categories of service listed in this section are covered under every medical program, nor do they represent a contract for services. Services are subject to the exclusions, limitations, and eligibility requirements contained in department rules.

(3) Services covered under each listed category:

(a) Are determined by the department after considering available evidence relevant to the service or equipment to:

(i) Determine efficacy, effectiveness, and safety;

(ii) Determine impact on health outcomes;

(iii) Identify indications for use;

(iv) Compare alternative technologies; and

(v) Identify sources of credible evidence that use and report evidence-based information.

(b) May require prior authorization (see WAC 388-501-0165), or expedited authorization when allowed by the department.

(c) Are paid for by the department and subject to review both before and after payment is made. The department or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The department does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the department, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the department as required under chapter 388-502 WAC;

(c) Are included in a department waiver program identified in chapter 388-515 WAC; or

(d) Are covered by a third-party payer (see WAC 388-501-0200), including medicare, if the third-party payer has not made a determination on the claim or has not been billed by the provider.

(5) **Scope of covered service categories.** The following table lists the department's covered categories of healthcare services.

• Under the four program columns (CN, MN, MCS, and AEM), the letter "C" means a service category is covered for that program, subject to any limitations listed in the specific medical assistance program WAC and department issuances.

• The letter "N" means a service category is not covered under that program.

• The letter "E" means the service category is available on ly if it is necessary to treat the client's emergency medical condition and may require prior authorization from the department.

• Refer to WAC 388-501-0065 for a description of each service category and for the specific program WAC containing the limitations and exclusions to services.

Service Categories	CN*	MN	MCS	AEM
(a) Adult day health	C	C	N	E
(b) Ambulance (ground and air)	C	C	C	E
(c) Blood processing/administration	C	C	C	E
(d) Dental services	C	C	C	E
(e) Detoxification	C	C	C	E
(f) Diagnostic services (lab & x-ray)	C	C	C	E
(g) Family planning services	C	C	C	E
(h) Healthcare professional services	C	C	C	E
(i) Hearing care (audiology/hearing exams/aids)	C	C	C	E
(j) Home health services	C	C	C	E
(k) Hospice services	C	C	N	E
(l) Hospital services - inpatient/outpatient	C	C	C	E
(m) Intermediate care facility/services for mentally retarded	C	C	C	E
(n) Maternity care and delivery services	C	C	N	E
(o) Medical equipment, durable (DME)	C	C	C	E
(p) Medical equipment, nondurable (MSE)	C	C	C	E
(q) Medical nutrition services	C	C	C	E
(r) Mental health services	C	C	C	E
(s) Nursing facility services	C	C	C	E
(t) Organ transplants	C	C	C	N
(u) Out-of-state services	C	C	N	E
(v) Oxygen/respiratory services	C	C	C	E
(w) Personal care services	C	C	N	N
(x) Prescription drugs	C	C	C	E
(y) Private duty nursing	C	C	N	E
(z) Prosthetic/orthotic devices	C	C	C	E
(aa) School medical services	C	C	N	N
(bb) Substance abuse services	C	C	C	E
(cc) Therapy -occupational/physical/speech	C	C	C	E
(dd) Vision care (exams/lenses)	C	C	C	E

*Clients enrolled in the State Children's Health Insurance Program and the Children's Health Program receive CN scope of medical care.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0060, filed 11/30/06, effective 1/1/07.]

WAC 388-501-0065 Healthcare coverage—Description of covered categories of service. This rule provides a brief description of the medical, dental, mental health, and substance abuse service categories listed in the table in WAC 388-501-0060. The description of services under each category is not intended to be all inclusive.

(1) For categorically needy (CN), medically needy (MN), and medical care services (MCS), refer to the WAC citations listed in the following descriptions for specific details regarding each service category. For Alien Emergency Medical (AEM) services, refer to WAC 388-438-0110.

(2) The following service categories are subject to the exclusions, limitations, and eligibility requirements contained in department rules:

(a) **Adult day health—**Skilled nursing services, counseling, therapy (physical, occupational, speech, or audiology), personal care services, social services, general therapeutic activities, health education, nutritional meals and snacks, supervision, and protection. [WAC 388-71-0702 through 388-71-0776]

(b) **Ambulance—**Emergency medical transportation and ambulance transportation for nonemergency medical needs. [WAC 388-546-0001 through 388-546-4000]

(c) **Blood processing/administration—**Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. [WAC 388-550-1400 and 388-550-1500]

(d) **Dental services—**Diagnosis and treatment of dental problems including emergency treatment and preventive care. [Chapters 388-535 and 388-535A WAC]

(e) **Detoxification—**Inpatient treatment performed by a certified detoxification center or in an inpatient hospital setting. [WAC 388-800-0020 through 388-800-0035; and 388-550-1100]

(f) **Diagnostic services—**Clinical testing and imaging services. [WAC 388-531-0100; 388-550-1400 and 388-550-1500]

(g) **Family planning services—**Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. [WAC 388-532-530]

(h) **Healthcare professional services—**Office visits, emergency room, nursing facility, home-based, and hospital-based care; surgery, anesthesia, pathology, radiology, and laboratory services; obstetric services; kidney dialysis and renal disease services; osteopathic care, podiatry services, physiatry, and pulmonary/respiratory services; and allergen immunotherapy. [Chapter 388-531 WAC]

(i) **Hearing care—**Audiology; diagnostic evaluations; hearing exams and testing; and hearing aids. [WAC 388-544-1200 and 388-544-1300; 388-545-700; and 388-531-0100]

(j) **Home health services—**Intermittent, short-term skilled nursing care, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. [WAC 388-551-2000 through 388-551-2220]

(k) **Hospice services—**Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. [WAC 388-551-1210 through 388-551-1850]

(l) **Hospital services—Inpatient/outpatient—**Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. [Chapter 388-550 WAC]

(m) **Intermediate care facility/services for mentally retarded—**Habilitative training, health-related care, supervision, and residential care. [Chapter 388-835 WAC]

(n) **Maternity care and delivery services—**Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, and community health worker visits. [WAC 388-533-0330]

(o) **Medical equipment, durable (DME)—**Wheelchairs, hospital beds, respiratory equipment; prosthetic and orthotic devices; casts, splints, crutches, trusses, and braces. [WAC 388-543-1100]

(p) **Medical equipment, nondurable (MSE)—**Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, transcutaneous electrical nerve stimulators (TENS) supplies, and urological supplies. [WAC 388-543-2800]

(q) **Medical nutrition services—**Enteral and parenteral nutrition, including supplies. [Chapters 388-553 and 388-554 WAC]

(r) **Mental health services—**Inpatient and outpatient psychiatric services and community mental health services. [Chapter 388-865 WAC]

(s) **Nursing facility services—**Nursing, therapies, dietary, and daily care services. [Chapter 388-97 WAC]

(t) **Organ transplants—**Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. [WAC 388-550-1900 and 388-550-2000, and 388-556-0400]

(u) **Out-of-state services—**Emergency services; prior authorized care. Services provided in bordering cities are treated as if they were provided in state. [WAC 388-501-0175 and 388-501-0180; 388-531-1100; and 388-556-0500]

(v) **Oxygen/respiratory services—**Oxygen, oxygen equipment and supplies; oxygen and respiratory therapy, equipment, and supplies. [Chapter 388-552 WAC]

(w) **Personal care services—**Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). [WAC 388-106-0010, [388-106-]0300, [388-106-]0400, [388-106-]0500, [388-106-]0600, [388-106-]0700, [388-106-]0720 and [388-106-]0900]

(x) **Prescription drugs—**Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. [WAC 388-530-1100] Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(y) **Private duty nursing—**Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. [WAC 388-551-3000.] For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(z) **Prosthetic/orthotic devices—**Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. [WAC 388-543-1100]

(aa) **School medical services—**Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). [Chapter 388-537 WAC]

(bb) **Substance abuse services—**Chemical dependency assessment, case management services, and treatment services. [WAC 388-533-0701 through 388-533-0730; 388-556-0100 and 388-556-0400; and 388-800-0020]

(cc) **Therapy—Occupational/physical/speech—**Evaluations, assessments, and treatment. [WAC 388-545-300, 388-545-500, and 388-545-700]

(dd) **Vision care—**Eye exams, refractions, frames, lenses, ocular prosthetics, and surgery. [WAC 388-544-0250 through 388-544-0550]

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0065, filed 11/30/06, effective 1/1/07.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

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 sanipractice;

(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 service(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) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person, entity or program that is or may be liable to provide coverage for the illness or injuries for which the department is providing assistance or residential care.

(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, 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 74.09.180.

(4) The department is not responsible for medical care payment(s) 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 the client is otherwise eligible for medical care.

(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 judgment as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.040 through 43.20B.-070, RCW 74.09.180 and 74.09.185.

(6) Notice to the department and determining the reimbursement amount:

(a) The client or the client's legal representative must notify the department in writing at the time of filing any claim against a third party, commencing an action at law, negotiating a settlement, or accepting an offer from the liable third party. Written notices to the department under this section should be sent to:

Health and Recovery Services Administration
COB Casualty Unit
PO Box 45561
Olympia, WA 98504-5561
Fax (360) 753-3077

(b) The client or the client's legal representative must provide the department with documentation proposing allocation of damages, if any, to be used for settlement or to be proven at trial.

(c) Where damages, including medical damages, have not been designated in the settlement or judgment, the client or the client's legal representative must contact the department to determine the appropriate reimbursement amount for payments the department made for the client's benefit.

(d) If the client and the department are unable to reach an agreement as to the appropriate reimbursement amount, any party may bring a motion in the superior court for a hearing to determine the amount of reimbursement to the department from settlement or judgment proceeds.

(7) 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 43.20B.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: 42 U.S.C. §§ 1396a, 1396k, 1396p, chapter 43.20B RCW, RCW 74.08.090, 74.09.180, 74.09.185. 08-17-046, § 388-501-0100, filed 8/14/08, effective 12/1/08. 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.]

WAC 388-501-0125 Advance directives. In this section "advance directive" means a written instruction, recognized under state law, relating to the provision of health care when an individual is incapacitated.

(1) All agencies, health maintenance organizations (HMOs), and facilities including hospitals, critical access hospitals, skilled nursing and nursing facilities, and providers of in-home care services that serve medical assistance clients eighteen years of age or older must have written policies and procedures concerning advance directives.

(2) The agencies, HMOs, and facilities must give the following information to each adult client, in writing and orally, and in a language the client understands:

(a) A statement about the client's right to:

(i) Make decisions concerning the client's medical care;

(ii) Accept or refuse surgical or medical treatment;

(iii) Execute an advance directive;

(iv) Revoke an advance directive at any time;

(b) The written policies of the agency, HMO, or facility concerning advance directives, including any policy that would preclude it from honoring the client's advance directive; and

(c) The client's rights under state law.

(3) The agencies, HMOs, and facilities must provide the information described in subsection (2) of this section to adult clients as follows:

(a) Hospitals at the time the client is admitted as an inpatient;

(b) Nursing facilities at the time the client is admitted as a resident;

(c) Providers of in-home care services before the client comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered;

(d) Hospice programs at the time the client initially receives hospice care from the program; and

(e) HMOs at the time the client enrolls with the organization.

(4) If the client is incapacitated at the time of admittance or enrollment and is unable to receive information or articulate whether or not the client has executed an advance directive, the agencies, HMOs, and facilities:

(a) May give information about advance directives to the person authorized by RCW 7.70.065 to make decisions regarding the client's health care;

(b) Must document in the client's file that the client was unable to communicate whether an advance directive exists if no one comes forward with a previously executed advance directive; and

(c) Must give the information described in subsection (2) to the client once the client is no longer incapacitated.

(5) The agencies, HMOs, and facilities must:

(a) Review each client's medical record prior to admittance or enrollment to determine if the client has an advance directive;

(b) Honor the directive or follow the process explained in subsection (6); and

(c) Not refuse, put conditions on care, or otherwise discriminate against a client based on whether or not the client has executed an advance directive.

(6) If an agency, HMO, or facility has a policy or practice that would keep it from honoring a client's advance directive, the facility or organization must:

(a) Tell the client prior to admission or enrollment or when the client executes the directive;

(b) Provide the client with a statement clarifying the differences between institution-wide conscience objections and those that may be raised by individual physicians and explaining the range of medical conditions or procedures affected;

(c) Prepare and keep a written plan of intended actions according to the requirements in RCW 70.122.060 if the client still chooses to retain the facility or organization; and

(d) Make a good faith effort to transfer the client to another health care practitioner who will honor the directive if the client chooses not to retain the facility or organization.

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility or organization for refusing to withhold or withdraw life-sustaining treatment.

(8) The agencies, HMOs, and facilities must document, in a prominent place in each client's medical record, whether or not the client has executed an advance directive.

(9) The agencies, HMOs, and facilities must educate staff and the community on issues concerning advance directives.

(10) The agencies, HMOs, and facilities must comply with state and federal laws and regulations concerning advance directives, including but not limited to: 42 USC 1396a, subsection (w); 42 CFR 417.436; 42 CFR 489 Subpart I; and chapter 70.122 RCW.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-19-050, § 388-501-0125, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 74.08.-090. 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

WAC 388-501-0135 Patient review and coordination (PRC). (1) **Patient review and coordination (PRC)** program, formerly known as the patient review and restriction (PRR) program, coordinates care and ensures that clients selected for enrollment in PRC use services appropriately and in accordance with department rules and policies.

(a) PRC applies to medical assistance fee-for-service and managed care clients. PRC does not apply to clients eligible for the family planning only program.

(b) PRC is authorized under federal medicaid law by 42 USC 1396n (a)(2) and 42 CFR 431.54.

(2) **Definitions.** The following definitions apply to this section only:

"Appropriate use"—Use of healthcare services that are adapted to or appropriate for a client's healthcare needs.

"Assigned provider"—A department-enrolled healthcare provider or one participating with a department contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for a fee-for-service or managed care client in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a controlled substances prescriber, and a hospital for nonemergent hospital services.

"At-risk"—A term used to describe one or more of the following:

(a) A client with a medical history of:

• Indications of forging or altering prescriptions;

• Seeking and/or obtaining healthcare services at a frequency or amount that is not medically necessary;

• Potential life-threatening events or life-threatening conditions that required or may require medical intervention.

(b) Behaviors or practices that could jeopardize a client's medical treatment or health including, but not limited to:

• Referrals from social services personnel about inappropriate behaviors or practices that places the client at risk;

• Noncompliance with treatment;

• Paying cash for controlled substances;

• Positive urine drug screen for illicit street drugs or nonprescribed controlled substances; or

• Unauthorized use of a client's medical assistance identification card or for an unauthorized purpose.

"Care management"—Services provided to clients with multiple health, behavioral, and social needs in order to improve care coordination, client education, and client self-management skills.

"Client"—A person enrolled in a department healthcare program and receiving service from fee-for-service provider(s) or a managed care organization (MCO), contracted with the department.

"Conflicting"—Drugs and/or healthcare services that are incompatible and/or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated"—To indicate or show a medical treatment or procedure is inadvisable or not recommended or warranted.

"Controlled substances prescriber"—Any of the following healthcare professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, uniform controlled substance act) for a legitimate medical purpose:

• A physician under chapter 18.71 RCW;

• A physician assistant under chapter 18.71A RCW;

• An osteopathic physician under chapter 18.57 RCW;

• An osteopathic physician assistant under chapter 18.57A RCW; and

• An advanced registered nurse practitioner under chapter 18.79 RCW.

"Duplicative"—Applies to the use of the same or similar drugs and healthcare services without due justification. Example: A client receives healthcare services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

"Just cause"—A legitimate reason to justify the action taken, including but not limited to, protecting the health and safety of the client.

"Managed care organization" or **"MCO"**—An organization having a certificate of authority or certificate of registration from the office of insurance commissioner, that contracts with the department under a comprehensive risk con-

tract to provide prepaid healthcare services to eligible medical assistance clients under the department's managed care programs.

"Managed care client"—A medical assistance client enrolled in, and receiving healthcare services from, a department-contracted managed care organization (MCO).

"Primary care provider" or **"PCP"**—A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides healthcare services to a client, initiates referrals for specialty and ancillary care, and maintains the client's continuity of care.

(3) **Clients selected for PRC review.** The department or MCO selects a client for PRC review when either or both of the following occur:

(a) A utilization review report indicates the client has not utilized healthcare services appropriately; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals to the department or MCO.

(4) **When a fee-for-service client is selected for PRC review** the prior authorization process as defined in chapter 388-530 WAC may be required:

(a) Prior to or during a PRC review; or

(b) When currently in the PRC program.

(5) **Review for placement in the PRC program.** When the department or MCO selects a client for PRC review, the department or MCO staff, with clinical oversight, reviews a client's medical and/or billing history to determine if the client has utilized healthcare services at a frequency or amount that is not medically necessary (42 CFR 431.54(e)).

(6) **Utilization guidelines for PRC placement.** Department or MCO staff use the following utilization guidelines to determine PRC placement. A client may be placed in the PRC program when medical and/or billing histories document any of the following:

(a) Any two or more of the following conditions occurred in a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Received services from four or more different providers, including physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs);

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received ten or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers;

(v) Received similar services from two or more providers in the same day; or

(vi) Had ten or more office visits.

(b) Any one of the following occurred within a period of ninety consecutive calendar days in the previous twelve months. The client:

(i) Made two or more emergency department visits;

(ii) Has a medical history that indicates "at-risk" utilization patterns;

(iii) Made repeated and documented efforts to seek healthcare services that are not medically necessary; or

(iv) Has been counseled at least once by a health care provider, or a department or MCO staff member, with clinical oversight, about the appropriate use of healthcare services.

(c) The client received prescriptions for controlled substances from two or more different prescribers in any one month in a period of ninety consecutive days in the previous twelve months.

(d) The client's medical and/or billing history demonstrates a pattern of the following at any time in the previous twelve months:

(i) The client has a history of using healthcare services in a manner that is duplicative, excessive, or contraindicated; or

(ii) The client has a history of receiving conflicting healthcare services, drugs, or supplies that are not within acceptable medical practice.

(7) **PRC review results.** As a result of the PRC review, the department or MCO staff may take any of the following steps:

(a) Determine that no action is needed and close the client's file;

(b) Send the client and, if applicable, the client's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the PRC program; or

(c) Determine that the utilization guidelines for PRC placement establish that the client has utilized healthcare services at an amount or frequency that is not medically necessary, in which case the department or MCO will take one or more of the following actions:

(i) Refer the client for education on appropriate use of healthcare services;

(ii) Refer the client to other support services or agencies; or

(iii) Place the client into the PRC program for an initial placement period of twenty-four months.

(8) **Initial placement in the PRC program.** When a client is initially placed in the PRC program:

(a) The department or MCO places the client for twenty-four months with one or more of the following types of healthcare providers:

(i) Primary care provider (PCP) (as defined in subsection (2) of this section);

(ii) Pharmacy;

(iii) Controlled substances prescriber;

(iv) Hospital (for nonemergent hospital services); or

(v) Another qualified provider type, as determined by department or MCO program staff on a case-by-case basis.

(b) The managed care client will remain in the same MCO for no less than twelve months unless:

(i) The client moves to a residence outside the MCO's service area and the MCO is not available in the new location; or

(ii) The client's assigned provider no longer participates with the MCO and is available in another MCO, and the client wishes to remain with the current provider.

(c) A managed care client placed in the PRC program must remain in the PRC program for the initial twenty-four month period regardless of whether the client changes MCOs or becomes a fee-for-service client.

(d) A care management program may be offered to a client.

(9) **Notifying the client about placement in the PRC program.** When the client is initially placed in the PRC program, the department or the MCO sends the client and, if applicable, the client's authorized representative, a written notice containing at least the following components:

(a) Informs the client of the reason for the PRC program placement;

(b) Directs the client to respond to the department or MCO within ten business days of the date of the written notice about taking the following actions:

(i) Select providers, subject to department or MCO approval;

(ii) Submit additional healthcare information, justifying the client's use of healthcare services; or

(iii) Request assistance, if needed, from the department or MCO program staff.

(c) Informs the client of hearing or appeal rights (see subsection (14) of this section).

(d) Informs the client that if a response is not received within ten days of the date of the notice, the client will be assigned a provider(s) by the department or MCO.

(10) **Selection and role of assigned provider.** A client may be afforded a limited choice of providers.

(a) The following providers are not available:

(i) A provider who is being reviewed by the department or licensing authority regarding quality of care;

(ii) A provider who has been suspended or disqualified from participating as a department-enrolled or MCO-contracted provider; or

(iii) A provider whose business license is suspended or revoked by the licensing authority.

(b) For a client placed in the PRC program, the assigned:

(i) Provider(s) must be located in the client's local geographic area, in the client's selected MCO, and/or be reasonably accessible to the client.

(ii) Primary care provider (PCP) supervises and coordinates healthcare services for the client, including continuity of care and referrals to specialists when necessary. The PCP must be one of the following:

(A) A physician who meets the criteria as defined in chapter 388-502 WAC;

(B) An advanced registered nurse practitioner (ARNP) who meets the criteria as defined in chapter 388-502 WAC; or

(C) A licensed physician assistant (PA), practicing with a supervising physician.

(iii) Controlled substances prescriber prescribes all controlled substances for the client.

(iv) Pharmacy fills all prescriptions for the client.

(v) Hospital provides all nonemergent hospital services.

(c) A client placed in the PRC program cannot change assigned providers for twelve months after the assignments are made, unless:

(i) The client moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's local geographic area and is no longer reasonably accessible to the client;

(iii) The provider refuses to continue to serve the client;

(iv) The client did not select the provider. The client may request to change an assigned provider once within thirty calendar days of the initial assignment;

(v) The client's assigned provider no longer participates with the MCO. In this case, the client may select a new provider from the list of available providers in the MCO or follow the assigned provider to the new MCO.

(d) When an assigned prescribing provider no longer contracts with the department:

(i) All prescriptions from the provider are invalid thirty calendar days following the date the contract ends; and

(ii) All prescriptions from the provider are subject to applicable prescription drugs (outpatient) rules in chapter 388-530 WAC or appropriate MCO rules.

(iii) The client must choose or be assigned another provider according to the requirements in this section.

(11) **PRC placement periods.** The length of time for a client's PRC placement includes:

(a) The initial period of PRC placement, which is a minimum of twenty-four consecutive months.

(b) The second period of PRC placement, which is an additional thirty-six consecutive months.

(c) The third period and each subsequent period of PRC placement, which is an additional seventy-two months.

(12) **Department review of a PRC placement period.** The department or MCO reviews a client's use of healthcare services prior to the end of each PRC placement period described in subsection (11) of this section using the utilization guidelines in subsection (6) of this section.

(a) The department or MCO assigns the next PRC placement period if the utilization guidelines for PRC placement in subsection (6) apply to the client.

(b) When the department or MCO assigns a subsequent PRC placement period, the department or MCO sends the client and, if applicable, the client's authorized representative, a written notice informing the client:

(i) The reason for the subsequent PRC program placement;

(ii) The length of the subsequent PRC placement;

(iii) That the current providers assigned to the client continue to be assigned to the client during the subsequent PRC placement period;

(iv) That all PRC program rules continue to apply; and

(v) Of hearing or appeal rights (see subsection (14) of this section);

(vi) Of the rules that support the decision.

(c) The department may remove a client from PRC placement if the client:

(i) Successfully completes a treatment program that is provided by a chemical dependency service provider certified by the department under chapter 388-805 WAC;

(ii) Submits documentation of completion of the approved treatment program to the department; and

(iii) Maintains appropriate use of healthcare services within the utilization guidelines described in subsection (6) for six months after the date the treatment ends.

(d) The department or MCO determines the appropriate placement period for a client who has been placed back into the program.

(e) A client will remain placed in the PRC program regardless of change in eligibility program type or change in address.

(13) **Client financial responsibility.** A client placed in the PRC program may be billed by a provider and held financially responsible for healthcare services when the client obtains nonemergent services and the provider who renders the services is not assigned or referred under the PRC program.

(14) **Right to hearing or appeal.**

(a) A fee-for-service client who believes the department has taken an invalid action pursuant to this section may request a hearing.

(b) A managed care client who believes the MCO has taken an invalid action pursuant to this section or chapter 388-538 WAC must exhaust the MCO's internal appeal process set forth in WAC 388-538-110 prior to requesting a hearing. Managed care clients can not change MCOs until the appeal or hearing is resolved and there is a final ruling.

(c) A client must request the hearing or appeal within ninety calendar days after the client receives the written notice of placement in the PRC program.

(d) The department conducts a hearing according to chapter 388-02 WAC. Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 388-02-0010.

(e) A client who requests a hearing or appeal within ten calendar days from the date of the written notice of an initial PRC placement period under subsection (11)(a) of this section will not be placed in the PRC program until the date an initial order is issued that supports the client's placement in the PRC program or otherwise ordered by an administrative law judge (ALJ).

(f) A client who requests a hearing or appeal more than ten calendar days from the date of the written notice under subsection (9) of this section will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(g) A client who requests a hearing or appeal within ninety days from the date of receiving the written notice under subsection (9) of this section and who has already been assigned providers will remain placed in the PRC program unless a final administrative order is entered that orders the client's removal from the program.

(h) An administrative law judge (ALJ) may rule that the client be placed in the PRC program prior to the date the record is closed and prior to the date the initial order is issued based on a showing of just cause.

(i) The client who requests a hearing challenging placement into the PRC program has the burden of proving the department's or MCO's action was invalid. For standard of proof, see WAC 388-02-0485.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. 431.51, 431.54(e) and 456.1; 42 U.S.C. 1396n. 08-05-010, § 388-501-0135, filed 2/7/08, effective 3/9/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.04.055, and 42 C.F.R. 431.54. 06-14-062, § 388-501-0135, filed 6/30/06, effective 7/31/06. Statutory Authority: RCW 74.08.090, 74.04.055, and 42 C.F.R. Subpart B 431.51, 431.54 (e) and (3), and 456.1. 04-01-099, § 388-501-0135, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

WAC 388-501-0160 Exception to rule—Request for a noncovered healthcare service. A client and/or the client's provider may request the department to pay for a noncovered healthcare service. This is called an exception to rule.

(1) The department cannot approve an exception to rule if the requested service is excluded under state statute.

(2) The item or service(s) for which an exception is requested must be of a type and nature which falls within accepted standards and precepts of good medical practice;

(3) All exception requests must represent cost-effective utilization of medical assistance program funds as determined by the department;

(4) A request for an exception to rule must be submitted to the department in writing within ninety days of the date of the written notification denying authorization for the noncovered service. For the department to consider the exception to rule request:

(a) The client and/or the client's healthcare provider must submit sufficient client-specific information and documentation to health and recovery services administration's medical director or designee which demonstrate the client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s).

(b) The client's healthcare professional must certify that medical treatment or items of service which are covered under the client's medical assistance program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:

(i) Medically ineffective in the treatment of the client's condition; or

(ii) Inappropriate for that specific client.

(5) Within fifteen business days of receiving the request, the department sends written notification to the provider and the client:

(a) Approving the exception to rule request;

(b) Denying the exception to rule request; or

(c) Requesting additional information.

(i) The additional information must be received by the department within thirty days of the date the information was requested.

(ii) The department approves or denies the exception to rule request within five business days of receiving the additional information.

(iii) If the requested information is insufficient or not provided within thirty days, the department denies the exception to rule request.

(6) The HRSA medical director or designee evaluates and considers requests on a case-by-case basis. The HRSA medical director has final authority or approve or deny a request for exception to rule.

(7) Clients do not have a right to a fair hearing on exception to rule decisions.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-501-0160, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090.

94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

WAC 388-501-0165 Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment. (1) This section applies to fee-for-service (FFS) requests for medical or dental services and medical equipment that:

(a) Are identified as covered services or EPSDT services; and

(b) Require prior authorization by the department.

(2) The following definitions and those found in WAC 388-500-0005 apply to this section:

"Controlled studies"—Studies in which defined groups are compared with each other to reduce bias.

"Credible evidence"—Type I-IV evidence or evidence-based information from any of the following sources:

- Clinical guidelines
- Government sources
- Independent medical evaluation (IME)
- Independent review organization (IRO)
- Independent technology assessment organizations
- Medical and hospital associations
- Policies of other health plans
- Regulating agencies (e.g., Federal Drug Administration or Department of Health)
- Treating provider
- Treatment pathways

"Evidence-based"—The ordered and explicit use of the best evidence available (see "hierarchy of evidence" in subsection (6)(a) of this section) when making health care decisions.

"Health outcome"—Changes in health status (mortality and morbidity) which result from the provision of health care services.

"Institutional review board (IRB)"—A board or committee responsible for reviewing research protocols and determining whether:

(1) The rights and welfare of human subjects are adequately protected;

(2) The risks to individuals are minimized and are not unreasonable;

(3) The risks to individuals are outweighed by the potential benefit to them or by the knowledge to be gained; and

(4) The proposed study design and methods are adequate and appropriate in the light of stated study objectives.

"Independent review organization (IRO)"—A panel of medical and benefit experts intended to provide unbiased, independent, clinical, evidence-based reviews of adverse decisions.

"Independent medical evaluation (IME)"—An objective medical examination of the client to establish the medical facts.

"Provider"—The individual who is responsible for diagnosing, prescribing, and providing medical, dental, or mental health services to department clients.

(3) The department authorizes, on a case-by-case basis, requests described in subsection (1) when the department determines the service or equipment is medically necessary as defined in WAC 388-500-0005. The process the department uses to assess medical necessity is based on:

(a) The evaluation of submitted and obtainable medical, dental, or mental health evidence as described in subsections (4) and (5) of this section; and

(b) The application of the evidence-based rating process described in subsection (6) of this section.

(4) The department reviews available evidence relevant to a medical, dental, or mental health service or equipment to:

(a) Determine its efficacy, effectiveness, and safety;

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Evaluate pertinent client information;

(e) Compare to alternative technologies; and

(f) Identify sources of credible evidence that use and report evidence-based information.

(5) The department considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition, including but not limited to:

(a) A client-specific physiological description of the disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) Pertinent X-ray and/or imaging reports;

(d) Individual patient records pertinent to the case or request;

(e) Photographs and/or videos when requested by the department; and

(f) Objective medical/dental/mental health information such as medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.

(6) The department uses the following processes to determine whether a requested service described in subsection (1) is medically necessary:

(a) **Hierarchy of evidence—How defined.** The department uses a hierarchy of evidence to determine the weight given to available data. The weight of medical evidence depends on objective indicators of its validity and reliability including the nature and source of the evidence, the empirical characteristics of the studies or trials upon which the evidence is based, and the consistency of the outcome with comparable studies. The hierarchy (in descending order with Type I given the greatest weight) is:

(i) Type I: Meta-analysis done with multiple, well-designed controlled studies;

(ii) Type II: One or more well-designed experimental studies;

(iii) Type III: Well-designed, quasi-experimental studies such as nonrandomized controlled, single group pre-post, cohort, time series, or matched case-controlled studies;

(iv) Type IV: Well-designed, nonexperimental studies, such as comparative and correlation descriptive, and case studies (uncontrolled); and

(v) Type V: Credible evidence submitted by the provider.

(b) **Hierarchy of evidence—How classified.** Based on the quality of available evidence, the department determines if the requested service is effective and safe for the client by classifying it as an **"A," "B," "C,"** or **"D"** level of evidence:

(i) **"A" level evidence:** Shows the requested service or equipment is a proven benefit to the client's condition by

strong scientific literature and well-designed clinical trials such as Type I evidence or multiple Type II evidence or combinations of Type II, III or IV evidence with consistent results (An "A" rating cannot be based on Type III or Type IV evidence alone).

(ii) **"B" level evidence:** Shows the requested service or equipment has some proven benefit supported by:

(A) Multiple Type II or III evidence or combinations of Type II, III or IV evidence with generally consistent findings of effectiveness and safety (A **"B"** rating cannot be based on Type IV evidence alone); or

(B) Singular Type II, III, or IV evidence in combination with department-recognized:

(I) Clinical guidelines; or

(II) Treatment pathways; or

(III) Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

(iii) **"C" level evidence:** Shows only weak and inconclusive evidence regarding safety and/or efficacy such as:

(A) Type II, III, or IV evidence with inconsistent findings; or

(B) Only Type V evidence is available.

(iv) **"D" level evidence:** Is not supported by any evidence regarding its safety and efficacy, for example that which is considered investigational or experimental.

(c) **Hierarchy of evidence—How applied.** After classifying the available evidence, the department:

(i) Approves **"A"** and **"B"** rated requests if the service or equipment:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is not more costly than an equally effective alternative treatment.

(ii) Approves a **"C"** rated request only if the provider shows the requested service is the optimal intervention for meeting the client's specific condition or treatment needs, and:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is less costly to the department than an equally effective alternative treatment; and

(C) Is the next reasonable step for the client in a well-documented tried-and-failed attempt at evidence-based care.

(iii) Denies **"D"** rated requests unless:

(A) The requested service or equipment has a humanitarian device exemption from the Food And Drug Administration (FDA); or

(B) There is a local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the department and the requesting provider.

(7) Within fifteen days of receiving the request from the client's provider, the department reviews all evidence submitted and:

(a) Approves the request;

(b) Denies the request if the requested service is not medically necessary; or

(c) Requests the provider submit additional justifying information. The department sends a copy of the request to the client at the same time.

(i) The provider must submit the additional information within thirty days of the department's request.

(ii) The department approves or denies the request within five business days of the receipt of the additional information.

(iii) If the provider fails to provide the additional information, the department will deny the requested service.

(8) When the department denies all or part of a request for a covered service(s) or equipment, the department sends the client and the provider written notice, within ten business days of the date the information is received, that:

(a) Includes a statement of the action the department intends to take;

(b) Includes the specific factual basis for the intended action;

(c) Includes reference to the specific WAC provision upon which the denial is based;

(d) Is in sufficient detail to enable the recipient to:

(i) Learn why the department's action was taken; and

(ii) Prepare an appropriate response.

(e) Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;

(f) Includes the client's administrative hearing rights;

(g) Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and

(h) Includes examples(s) of "lesser cost alternatives" that permit the affected party to prepare an appropriate response.

(9) If an administrative hearing is requested, the department or the client may request an independent review organization (IRO) or independent medical examination (IME) to provide an opinion regarding whether the requested service or equipment is medically necessary. The department will pay for the independent assessment if the department agrees that it is necessary, or an administrative law judge orders the assessment.

[Statutory Authority: RCW 74.04.050, 74.08.090. 05-23-031, § 388-501-0165, filed 11/8/05, effective 12/9/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035. 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

WAC 388-501-0169 Healthcare coverage—Limitation extension. This section addresses requests for limitation extensions (additional covered services when a client has received the maximum services allowed under specific healthcare program rules). The department does not pay for services exceeding the maximum allowed until authorization is obtained.

(1) No extension of covered services will be authorized when prohibited by specific program rules.

(2) When an extension is not prohibited by specific program rules, a client or the client's provider may request a limitation extension.

(3) Under fee-for-service (FFS), the department evaluates requests for limitation extensions using the process described in WAC 388-501-0165. For a managed care

enrollee, the client's managed care organization (MCO) evaluates requests for limitation extensions according to the MCO's prior authorization process.

(4) In addition to subsection (3), both the department and MCO consider the following in evaluating a request for a limitation extension:

(a) The level of improvement the client has shown to date related to the requested service and the reasonably calculated probability of continued improvement if the requested service is extended; and

(b) The reasonably calculated probability the client's condition will worsen if the requested service is not extended.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0169, filed 11/30/06, effective 1/1/07.]

WAC 388-501-0175 Medical care provided in bordering cities. (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

WAC 388-501-0180 Healthcare services provided outside the state of Washington—General provisions. WAC 388-501-0180 through 388-501-0184 apply only to services payable on a fee-for-service basis for Washington state medical assistance clients.

(1) Subject to the exceptions and limitations in this section, WAC 388-501-0182 and 388-501-0184, the department covers emergency and nonemergency out-of-state healthcare services provided to eligible Washington state medical assistance clients when the services are:

(a) Within the scope of the client's healthcare program as specified under chapter 388-501 WAC;

(b) Allowed to be provided outside the state of Washington by specific program WAC; and

(c) Medically necessary as defined in WAC 388-500-0005.

(2) The department does not cover services provided outside the state of Washington under the Involuntary Treatment Act (chapter 71.05 RCW and chapter 388-865 WAC), including designated bordering cities.

(3) When the department pays for covered healthcare services furnished to an eligible Washington state medical assistance client outside the state of Washington, its payment is payment in full according to 42 CFR 447.15. The department does not pay when the provider refuses to accept the department's payment as payment in full.

(4) The department determines coverage for transportation services provided out of state, including ambulance services, according to chapter 388-546 WAC.

(5) With the exception of designated bordering cities (see WAC 388-501-0175), if the client travels out of state expressly to obtain healthcare, the service(s) must be prior authorized by the department. See WAC 388-501-0182 for requirements related to out-of-state nonemergency treatment and WAC 388-501-0165 for the department's medical necessity determination process.

(6) The department does not cover healthcare services provided outside the United States and U.S. territories, with the exception of British Columbia, Canada. See WAC 388-501-0184 for limitations on coverage of healthcare provided to medical assistance clients in British Columbia, Canada.

(7) See WAC 388-502-0120 for provider requirements for payment of healthcare provided outside the state of Washington.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-501-0180, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0180, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

WAC 388-501-0182 Healthcare provided in another state or U.S. territory—Nonemergency. (1) This rule applies to nonemergency treatment situations occurring in another state or U.S. territory. Applicable situations include, but are not limited to:

(a) Healthcare services that the department has prior authorized for a client; and

(b) Healthcare services obtained by the client, independent of the department, while traveling or visiting.

(2) In accordance with the prior authorization process described in WAC 388-501-0165, except as specified in subsection (3) of this section, the department pays for covered nonemergency healthcare services provided to an eligible Washington state medical assistance client in another state or U.S. territory to the same extent that it pays for covered nonemergency services provided within the state of Washington when the department determines that:

(a) Services are medically necessary and the client's health will be endangered if the client is required to travel to the state of Washington to receive the needed care;

(b) Medically necessary services are not available in Washington state or designated bordering cities (see WAC 388-501-0175) and are more readily available in another state; or

(c) It is general practice for clients in a particular Washington state locality to use medically necessary resources in a bordering state.

(3) The department pays for covered nonemergency healthcare services furnished to an eligible Washington state medical assistance client in another state or U.S. territory, unless the out-of-state provider is unwilling to accept the department's payment as payment in full according to 42 CFR 447.15. The department does not pay when the provider refuses to accept the department's payment as payment in full.

(4) The department does not pay for medically necessary, nonsymptomatic treatment (i.e., preventive care) furnished outside the state of Washington unless it is furnished in a designated bordering city, which is considered the same as an in-state city for the purposes of healthcare coverage (see WAC 388-501-0175). Covered nonemergency services

requiring prior authorization, when provided in the state of Washington, also require prior authorization, when provided in a designated bordering city (see WAC 388-501-0165 for the department's medical necessity determination process).

(5) See WAC 388-501-0180 for additional information regarding healthcare services provided outside the state of Washington.

(6) The department's health and recovery services administration's (HRSA) assistant secretary or designee reviews all exception to rule (ETR) requests.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-501-0182, filed 3/31/08, effective 5/1/08.]

WAC 388-501-0184 Healthcare services provided outside of the United States and U.S. territories or in a foreign country. For the purposes of this section the term "healthcare services" does not include the diagnosis and treatment for alcohol and/or substance abuse and mental health services.

(1) The provisions of WAC 388-501-0182 apply to this section.

(2) The department does not pay for healthcare services furnished in a foreign country, except for medical services furnished in the province of British Columbia, Canada, under the conditions specified in this section. The department pays for medical services furnished in British Columbia to the following Washington state medical assistance clients only:

(a) Those who reside in Point Roberts, Washington;

(b) Those who reside in Washington communities along the border with British Columbia, Canada (see subsection (3) of this section for further clarification); and

(c) Members of the Canadian First Nations who live in Washington state.

(3) For those medical assistance clients identified in subsection (1) of this section, the department covers emergency and nonemergency medical services provided in British Columbia, Canada, when the services are:

(a) Within the scope of the client's healthcare program as specified in chapter 388-501 WAC;

(b) Allowed to be provided outside the United States and U.S. territories by specific program WAC; and

(c) Medically necessary as defined in WAC 388-500-0005.

(4) For those medical assistance clients identified in subsection (1) of this section, the department covers nonemergency medical services in British Columbia, Canada, only when:

(a) It is general practice for Washington state medical assistance clients residing in these particular localities to use medically necessary resources across the Canadian border; or

(b) The medical services in British Columbia are closer or more readily accessible to the client's Washington state residence. As applied to nonemergency medical services, the phrase "closer or more readily accessible to the client's Washington state residence" means:

(i) There is not a United States provider for the same service within twenty-five miles of the client's Washington state residence; and

(ii) The closest Canadian provider of service is closer than the closest U.S. provider of the service.

(5) The department does not cover services provided outside of the United States under the involuntary treatment act (chapter 71.05 RCW and chapter 388-865 WAC).

(6) When the department pays for covered medical services furnished to a Washington state medical assistance client in British Columbia, its payment is payment in full according to 42 CFR 447.15. The department does not pay when the provider refuses to accept the department's payment as payment in full.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-501-0184, filed 3/31/08, effective 5/1/08.]

WAC 388-501-0200 Third-party resources. (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00;00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0213 Case management services. (1) The department shall provide case management services to medical assistance recipients:

(a) By contract with providers of case management services.

(b) Limited to target groups of clients as determined by the contract.

(c) Limited to services as determined by the contract.

(2) Case management services are services which will assist clients in gaining access to needed medical, social, educational, and other services.

[00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-502-0205 Civil rights. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0205, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-010 (part).] Repealed by 00-15-050, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530.

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.

388-502-0250 Interest penalties—Providers. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.] Amended and decodified by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090. Later promulgation, see WAC 388-502-0130.

WAC 388-502-0010 Payment—Eligible providers defined. The department pays enrolled providers for covered healthcare services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

(a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and

(b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

(2) To enroll, an eligible provider must sign a core provider agreement with the department and receive a unique provider number; a provider may also sign a contract to enroll. (Note: Section 13 of the core provider agreement, DSHS 09-048 (REV. 06/2002), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.)

(3) Eligible providers listed in this subsection may request enrollment. Out-of-state providers listed in this subsection are subject to conditions in chapter 388-502 WAC.

(a) Professionals:

(i) Advanced registered nurse practitioners;

(ii) Anesthesiologists;

(iii) Audiologists;

(iv) Chiropractors;

(v) Dentists;

(vi) Dental hygienists;

(vii) Denturists;

(viii) Dietitians or nutritionists;

(ix) Marriage and family therapists, only as provided in WAC 388-531-1400;

(x) Maternity case managers;

(xi) Mental health counselors, only as provided in WAC 388-531-1400;

(xii) Midwives;

(xiii) Occupational therapists;

(xiv) Ophthalmologists;

(xv) Opticians;

(xvi) Optometrists;

(xvii) Orthodontists;

(xviii) Osteopathic physicians;

(xix) Podiatric physicians;

(xx) Pharmacists;

(xxi) Physicians;

(xxii) Physical therapists;

(xxiii) Psychiatrists;

(xxiv) Psychologists;

(xxv) Registered nurse delegators;

(xxvi) Registered nurse first assistants;

(xxvii) Respiratory therapists;

(xxviii) Social workers, only as provided in WAC 388-531-1400 and 388-531-1600;

(xxix) Speech/language pathologists;

(xxx) Radiologists; and

(xxxi) Radiology technicians (technical only);

(b) Agencies, centers and facilities:

(i) Adult day health centers;

(ii) Ambulance services (ground and air);

(iii) Ambulatory surgery centers (medicare-certified);

(iv) Birthing centers (licensed by the department of health);

(v) Blood banks;

(vi) Chemical dependency treatment facilities certified by the department of social and health services (DSHS), division of alcohol and substance abuse (DASA), and contracted through either:

(A) A county under chapter 388-810 WAC; or

(B) DASA to provide chemical dependency treatment services;

(vii) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);

(viii) Community AIDS services alternative agencies;

(ix) Community mental health centers;

(x) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;

(xi) Family planning clinics;

(xii) Federally qualified health centers (FQHC) (designated by the Centers for medicare and medicaid);

(xiii) Genetic counseling agencies;

(xiv) Health departments;

(xv) HIV/AIDS case management;

(xvi) Home health agencies;

(xvii) Hospice agencies;

(xviii) Hospitals;

(xix) Indian Health Service;

(xx) Tribal or urban Indian clinics;

(xxi) Inpatient psychiatric facilities;

(xxii) Intermediate care facilities for the mentally retarded (ICF-MR);

(xxiii) Kidney centers;

(xxiv) Laboratories (CLIA certified);

(xxv) Maternity support services agencies;

(xxvi) Neuromuscular and neurodevelopmental centers;

(xxvii) Nursing facilities (approved by DSHS aging and disability services);

(xxviii) Pharmacies;

(xxix) Private duty nursing agencies;

(xxx) Rural health clinics (medicare-certified);

(xxxi) Tribal mental health services (contracted through the DSHS mental health division); and

(xxxii) Washington state school districts and educational service districts.

(c) Suppliers of:

(i) Durable and nondurable medical equipment and supplies;

(ii) Infusion therapy equipment and supplies;

(iii) Prosthetics/orthotics;

(iv) Hearing aids; and

(v) Oxygen equipment and supplies;

(d) Contractors of:

(i) Transportation brokers;

(ii) Interpreter services agencies; and

(iii) Eyeglass and contact lens providers.

(4) Nothing in this chapter precludes the department from entering into other forms of written agreements to provide services to eligible clients.

(5) The department does not enroll licensed or unlicensed practitioners who are not specifically addressed in subsection (3) of this section. Ineligible providers include but are not limited to:

(a) Acupuncturists;

(b) Counselors, except as provided in WAC 388-531-1400;

(c) Sanipractors;

(d) Naturopaths;

(e) Homeopaths;

(f) Herbalists;

(g) Massage therapists;

(h) Social workers, except as provided in WAC 388-531-1400 and 388-531-1600; or

(i) Christian Science practitioners or theological healers.

[Statutory Authority: RCW 74.09.521. 08-12-030, § 388-502-0010, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.080, 74.09.120. 03-14-106, § 388-502-0010, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0020 General requirements for providers. (1) Enrolled providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

(i) Patient's name and date of birth;

(ii) Dates of services;

(iii) Name and title of person performing the service, if other than the billing practitioner;

(iv) Chief complaint or reason for each visit;

(v) Pertinent medical history;

(vi) Pertinent findings on examination;

(vii) Medications, equipment, and/or supplies prescribed or provided;

(viii) Description of treatment (when applicable);

(ix) Recommendations for additional treatments, procedures, or consultations;

(x) X rays, tests, and results;

(xi) Dental photographs and teeth models;

(xii) Plan of treatment and/or care, and outcome; and

(xiii) Specific claims and payments received for services.

(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;

(c) Make charts and records available to DSHS, its contractors, and the US 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;

(d) Bill the department according to department rules and billing instructions;

(e) Accept the payment from the department as payment in full;

(f) Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;

(g) Fully disclose ownership and control information requested by the department;

(h) Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap; and

(i) Provide all services according to federal and state laws and rules, and billing instructions issued by the department.

(2) A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0030 Denying, suspending, and terminating a provider's enrollment. (1) The department terminates enrollment or does not enroll or reenroll a provider if, in the department's judgement, it may be a danger to the health or safety of clients.

(2) Except as noted in subsection (3) of this section, the department does not enroll or reenroll a provider to whom any of the following apply:

(a) Has a restricted professional license;

(b) Has been terminated, excluded, or suspended from medicare/medicaid; or

(c) Has been terminated by the department for quality of care issues or inappropriate billing practices.

(3) The department may choose to enroll or reenroll a provider who meets the conditions in subsection (2) of this section if all of the following apply:

(a) The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;

(b) The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and

(c) If the United States Department of Health and Human Services (DHHS) or medicare suspended the provider from medicare, DHHS or medicare notifies the department that the provider may be reinstated.

(4) The department gives thirty days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:

(a) The provider is convicted of a criminal offense related to participation in the medicare/medicaid program;

(b) The provider's license, certification, accreditation, or registration is suspended or revoked;

(c) Federal funding is revoked;

(d) By investigation, the department documents a violation of law or contract;

(e) The MAA medical director or designee determines the quality of care provided endangers the health and safety of one or more clients; or

(f) The department determines the provider has intentionally used inappropriate billing practices.

(5) The department may terminate a provider's number if:

(a) The provider does not disclose ownership or control information;

(b) The provider does not submit a claim to the department for twenty-four consecutive months;

(c) The provider's address on file with the department is incorrect;

(d) The provider requests a new provider number (e.g., change in tax identification number or ownership); or

(e) The provider voluntarily withdraws from participation in the medical assistance program.

(6) Nothing in this chapter obligates the department to enroll all eligible providers who request enrollment.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0100 General conditions of payment. (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

(a) The service is within the scope of care of the client's medical assistance program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 388-502-0150;

(e) The provider bills according to department rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The department is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The department does not reimburse providers for medical services identified by the department as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (co-pays) (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);

(c) Emergency medical expense requirements (EMER); and

(d) Spenddown (see WAC 388-519-0110).

(4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and medical assistance before MAA makes any payment.

(5) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(6) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

(a) The department considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the department.

(7) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-502-0100, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0110 Conditions of payment—Medicare deductible and coinsurance. (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the medicare DRG as payment in full until the medicaid outlier threshold is reached. After the medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If medicare and medicaid cover the service, the department pays only the deductible and/or coinsurance up to medicare or medicaid's allowed amount, whichever is less. If only medicare and not medicaid covers the service, the department pays only the deductible and/or coinsurance up to medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for medicaid covered services when the client exhausts medicare benefits.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0120 Payment for healthcare services provided outside the state of Washington. (1) The department pays for healthcare services provided outside the state of Washington only when the service meets the provisions set forth in WAC 388-501-0180, 388-501-0182, 388-501-0184, and specific program WAC.

(2) With the exception of hospital services and nursing facilities, the department pays the provider of service in designated bordering cities as if the care was provided within the state of Washington (see WAC 388-501-0175).

(3) With the exception of designated bordering cities, the department does not pay for healthcare services provided to clients in medical care services (MCS) programs outside the state of Washington (see WAC 388-556-0500).

(4) With the exception of hospital services (see subsection (5) of this section), the department pays for healthcare services provided outside the state of Washington at the lower of:

(a) The billed amount; or

(b) The rate established by the Washington state medical assistance programs.

(5) The department pays for hospital services provided in designated bordering cities and outside the state of Washington in accordance with the provisions of WAC 388-550-3900, 388-550-4000, 388-550-4800 and 388-550-6700.

(6) The department pays nursing facilities located outside the state of Washington when approved by the aging and disability services administration (ADSA) at the lower of the billed amount or the adjusted statewide average reimbursement rate for in-state nursing facility care, only in the following limited circumstances:

(a) Emergency situations; or

(b) When the client intends to return to Washington state and the out-of-state stay is for:

(i) Thirty days or less; or

(ii) More than thirty days if approved by ADSA.

(7) To receive payment from the department, an out-of-state provider must:

(a) Have a signed agreement with the department;

(b) Meet the functionally equivalent licensing requirements of the state or province in which care is rendered;

(c) Meet the conditions in WAC 388-502-0100 and 388-502-0150;

(d) Satisfy all medicaid conditions of participation;

(e) Accept the department's payment as payment in full according to 42 CFR 447.15; and

(f) If a Canadian provider, bill at the U.S. exchange rate in effect at the time the service was provided.

(8) For covered services for eligible clients, MAA reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX medicaid program.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-502-0120, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

WAC 388-502-0130 Interest penalties—Providers. (1) Providers who are enrolled as contractors with the depart-

ment's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied. Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

WAC 388-502-0150 Time limits for providers to bill MAA. Providers may bill the **medical assistance administration (MAA)** for covered services provided to eligible clients.

(1) MAA requires providers to submit initial claims and adjust prior claims in a timely manner. MAA has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims, see subsections (7) and (8) of this section; and

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section.

(2) The provider must submit claims to MAA as described in MAA's billing instructions.

(3) Providers must submit their claim to MAA and have an internal control number (ICN) assigned by MAA within three hundred sixty-five days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders MAA to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) MAA may grant exceptions to the three hundred sixty-five-day time limit for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to MAA's satisfaction that there are other extenuating circumstances.

(5) MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to MAA's billing limits.

(6) When a client is covered by both medicare and MAA, the provider must bill medicare for the service before billing medicaid. If medicare:

(a) Pays the claim the provider must bill MAA within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, MAA requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) MAA allows providers to resubmit, modify, or adjust any claim, other than a prescription drug claim, with a timely ICN within thirty-six months of the date the service was provided to the client. This applies to any claim, other than a prescription drug claim, that met the time limits for an initial claim, whether paid or denied. MAA does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(8) The thirty-six-month period described in subsection (7) of this section does not apply to overpayments that a provider must refund to the department. After thirty-six months, MAA does not allow a provider to refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(9) MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within fifteen months of the date the service was provided to the client. After fifteen months, MAA does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements of this section, resulting in the claim not being paid by MAA.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0160 Billing a client. (1) A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay the provider because the provider failed to satisfy the conditions of payment in MAA billing instructions, this chapter, and other chapters regulating the specific type of service provided.

(2) The provider is responsible for verifying whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

(3) A provider may bill a client only if one of the following situations apply:

(a) The client is enrolled in medical assistance managed care and the client and provider comply with the requirements in WAC 388-538-095;

(b) The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for the service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request. The agreement must include each of the following elements to be valid:

(i) A statement listing the specific service to be provided;

(ii) A statement that the service is not covered by MAA;

(iii) A statement that the client chooses to receive and pay for the specific service; and

(iv) The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.

(c) The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

(d) The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA;

(e) The provider has documentation that the client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a MAA medical program. This documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the client's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection (3)(b) of this section regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection (4) of this section for that service;

(f) The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA; or

(g) The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a three-dollar copayment may be imposed on the client by the hospital, except when:

(i) Reasonable alternative access to care was not available;

(ii) The "indigent person" criteria in WAC 246-453-040(1) applies;

(iii) The client was eighteen years of age or younger;

(iv) The client was pregnant or within sixty days postpregnancy;

(v) The client is an American Indian or Alaska Native;

(vi) The client was enrolled in a MAA managed care plan, including primary care case management (PCCM);

(vii) The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or

(viii) The client receives waivered services such as community options program entry system (COPES) and community alternatives program (CAP).

(4) If a client becomes eligible for a covered service that has already been provided because the client:

(a) Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

(i) Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

(ii) Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;

(b) Receives a delayed certification as defined in WAC 388-500-0005, the provider must:

(i) Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

(ii) Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

(c) Receives a retroactive certification as defined in WAC 388-500-0005, the provider:

(i) Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and

(ii) May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

(5) Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstance described in subsection (3)(g) of this section.

(6) A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(a) Medical charts;

(b) Radiological or imaging films; and

(c) Laboratory or other diagnostic test results.

[Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090. 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0210 Statistical data-provider reports. (1) At the request of the medical assistance administration (MAA), all providers enrolled with MAA programs must submit full reports, as specified by MAA, of goods and services furnished to eligible medical assistance clients. MAA furnishes the provider with a standardized format to report these data.

(2) MAA analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to MAA's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with MAA, and any other interested organizations or individuals.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the medical assistance administration's (MAA) reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with MAA.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for MAA to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, MAA may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, MAA may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) MAA issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When MAA requests additional information, the contractor/provider has forty-five calendar days from the date of MAA's request to submit the additional information.

(ii) MAA issues a decision within thirty calendar days of receipt of the completed information.

(e) MAA may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from MAA. MAA does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) MAA may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that MAA grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with MAA. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to MAA within thirty calendar days after the contractor/provider receives the rate review decision. MAA does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) MAA conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) MAA considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

WAC 388-502-0230 Provider review and appeal. (1) As authorized by chapter 74.09 RCW, the medical assistance administration (MAA) monitors and reviews all providers who furnish medical, dental, or other services to eligible medical assistance clients. MAA determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments. Examples of provider reviews are:

(a) A review of all billing/medical/dental/service records for medical assistance clients;

(b) A statistical sampling of billing/medical/dental/service records for medical assistance clients, extrapolated per WAC 388-502-0240 (9), (10), and (11); and

(c) A review focused on selected billing/medical/dental/service records for medical assistance clients.

(2) The Washington State Health Professions Quality Assurance Commissions serve in an advisory capacity to MAA in conducting provider reviews and monitoring.

(3) MAA may determine that a provider's billing does not comply with program regulations or the provider is not meeting quality of care practices. MAA may do, but is not limited to, any of the following:

(a) Conduct prepay reviews of all claims the provider submits to MAA;

(b) Refer the provider to MAA's auditors (see WAC 388-502-0240);

(c) Refer the provider to medicaid's fraud control unit;

(d) Refer the provider to the appropriate state health professions quality assurance commission;

(e) Impose provisional stipulations for the provider to continue participation in medical assistance programs;

(f) Terminate the provider's participation in medical assistance programs;

(g) Assess a civil penalty against the provider, per RCW 74.09.210; and

(h) Recover any moneys that the provider received as a result of inappropriate payments.

(4) When any part of the time period that is reviewed or monitored falls on or before June 30, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request an administrative review hearing to dispute the action(s).

(a) The request for an administrative review hearing must be in writing and:

(i) Be sent within twenty-eight days of the date of the notice of action(s);

(ii) State the reason(s) why the provider thinks the action(s) are incorrect;

(iii) Be sent by certified mail (return receipt) or other means that provides proof of delivery to:

The Medical Assistance Administration
Attn: Deputy Assistant Secretary
P.O. Box 45500
Olympia WA 98504-5500

(b) The administrative review hearing consists of a review by MAA's deputy assistant secretary of all documents submitted by the provider and MAA. At the deputy assistant secretary's discretion, the administrative review hearing may be conducted in person, as a telephone conference, in written submissions, or a combination thereof.

(c) When a final decision is issued, the office of financial recovery collects any amount the provider is ordered to repay.

(d) The administrative review hearing referenced in this subsection is the final level of administrative review.

(5) When the entire time period that is reviewed or monitored falls on or after July 1, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s).

(a) The request for hearing must be in writing and;

(i) Be sent within twenty-eight days of the date of the notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:

The Office of Financial Recovery
P.O. Box 9501
Olympia, WA 98507-5501; and

(ii) State the reason(s) why the provider thinks the action(s) are incorrect.

(b) The office of administrative hearings schedules and conducts the hearing under the Administrative Procedure Act, chapter 34.05 RCW. MAA offers a pre-hearing/alternative dispute conference prior to the hearing.

(c) The office of financial recovery collects any amount the provider is ordered to repay.

(6) A provider who disagrees with a department action regarding termination may appeal the action per WAC 388-502-0260. The provider may request a dispute conference; the request must be:

(a) In writing;

(b) Sent within thirty days of the date the provider received the termination notice;

(c) Include a statement of the action(s) appealed and supporting justification; and

(d) Sent to:

DSHS Central Contract Services
P.O. Box 45811
Olympia, WA 98504-5811

(7) See WAC 388-502-0220 for rate reimbursement appeals. See WAC 388-502-0240 for appeals of audit findings. See WAC 388-502-0260 for appeals related to contracts other than MAA's core provider agreements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220. 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 388-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements. (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[Statutory Authority: RCW 74.08.090, 74.09.290. 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

WAC 388-502-0270 Review of department's provider dispute decision. (1) This section applies only when department rules allow review of a department dispute decision under this section. The deputy assistant secretary of the health and recovery services administration (HRSA) or designee conducts the review.

(2) Providers and former providers may request a review of a department dispute decision. The request must be in writing and sent to: HRSA, Attn: Deputy Assistant Secretary, PO Box 45504, Olympia, WA 98504-5504. The department must receive the written dispute review request within twenty-eight calendar days of the date on the department's written dispute decision.

(3) When the department receives a timely dispute review request, the deputy or designee may schedule a dispute review conference. "Dispute review conference" means an informal conference for the purpose of resolving disagreements between the department and a provider or former provider who is dissatisfied with a department decision. The dispute review conference is not governed by the administrative procedure act, chapter 34.05 RCW. If the deputy or designee chooses to schedule a dispute review conference, the deputy or designee will conduct the conference within ninety calendar days of the dispute review request unless the deputy or designee and the party requesting review agree to an extension.

(4) The deputy or designee will issue a dispute review decision to the provider or former provider requesting review within thirty calendar days of receiving the dispute review request or within thirty calendar days of the dispute review conference, whichever is later, unless both parties agree to an extension.

(5) The deputy review is the final level of department review for disputes to which this section applies.

[Statutory Authority: RCW 74.08.090. 08-12-012, § 388-502-0270, filed 5/27/08, effective 6/27/08.]

Chapter 388-502A WAC
PROVIDER AUDITS AND APPEALS

WAC

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

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-503-0305 Program priorities. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0305, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-503-0310 Categorically needy eligible persons. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.] Repealed by 99-19-091, filed 9/17/99, effective 10/18/99. Statutory Authority: RCW 74.08.090.

388-503-0320 Medically needy eligible persons. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-503-0320, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0320, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-005 and 388-99-010.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0100.

388-503-0350 Medical care services—GAU/ADATSA. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-503-0350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-126 and 388-83-006.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-529-0100.

388-503-0370 Medically indigent eligible persons. [Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-503-0370, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-503-0370, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-005 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-438-0100.

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.]

WAC 388-503-0510 How a client is determined "related to" a categorical program. (1) A person is related to the Supplemental Security Income (SSI) program if they are:

(a) Aged, blind, or disabled as defined in chapter 388-475 WAC; or

(b) Considered as eligible for SSI under chapter 388-475 WAC; or

(c) Children meeting the requirements of WAC 388-505-0210(5).

(2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program if they:

(a) Meet the program requirements for the TANF cash assistance programs or the requirements of WAC 388-505-0220; or

(b) Would meet such requirements except that the assistance unit's countable income exceeds the TANF program standards in WAC 388-478-0065.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-475, 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-503-0510, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-07-097, § 388-503-0510, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-503-0510, 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, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

WAC 388-503-0515 Medical coverage resulting from a cash grant. (1) Families or individuals eligible for SSI, SSI state supplement or TANF cash grants are automatically eligible for categorically needy (CN) medical coverage. These clients receive medical coverage benefits without making a separate application. Certification for CN medical coverage parallels that for the cash benefits.

(2) Upon termination of cash benefits as described in subsection (1) of this section, medical coverage continues until the client's eligibility for other medical coverage can be completed. Continuing medical coverage is terminated if the client does not cooperate with the eligibility redetermination process.

(3) Individuals eligible for state financial assistance (SFA) cash grants may receive medical coverage for:

(a) An emergent medical condition as described in WAC 388-438-0110; or

(b) Pregnancy as described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-503-0515, 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, § 388-503-0515, filed 7/31/98, effective 9/1/98.]

Chapter 388-505 WAC
FAMILY MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-505-0501	Eligibility—General. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0501, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-505-0505	Age. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-505-0510	Residence. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-505-0510, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-025.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-468-0010.
388-505-0520	Citizenship. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]-230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-505-0520, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 96-13-002 (Order 3983), § 388-505-0520, filed 6/6/96, effective 7/7/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-24-016 (Order 3923), § 388-505-0520, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0520, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-424-0005 and 388-424-0010.
388-505-0530	Social Security number. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-017.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-476-0005.

388-505-0560	Cooperation in securing medical support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0560, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-013.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-472-0005, 388-505-0540, 388-422-0005, 388-422-0010 and 388-422-0020.
388-505-0570	Good cause for noncooperation—Medical care support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0570, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-014.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-422-0020(4)(c).
388-505-0580	Resources. [Statutory Authority: RCW 74.08.090. 96-01-005 (Order 3932, # 100268), § 388-505-0580, filed 12/6/95, effective 1/6/96; 95-02-026 (Order 3817), § 388-505-0580, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-505-0580, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-026.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0015, 388-470-0020, 388-470-0040, 388-488-0005 and 388-450-0210.
388-505-0590	Income. [Statutory Authority: RCW 74.08.090. 95-17-031 (Order 3878), § 388-505-0590, filed 8/9/95, effective 9/9/95; 95-04-047 (Order 3827), § 388-505-0590, filed 1/25/95, effective 2/25/95; 94-10-065 (Order 3732), § 388-505-0590, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-041.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0005, 388-450-0015, 388-450-0210 and 388-450-0215.
388-505-0595	Trusts. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0595, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-041.] Repealed by 01-06-043, filed 3/5/01, effective 5/1/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500.

WAC 388-505-0110 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for CN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and

(c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) is eligible for CN medical coverage if the person:

(a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:

(i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;

(ii) Is ineligible for SSI benefits and/or state supplementary payments (SSP); and

(iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:

(A) All Title II COLA increases under P.L. 94-566, section 503 received by the client since their termination from SSI/SSP; and

(B) All Title II COLA increases received during the time period in subsection (1)(d)(iii)(A) of this section by the client's spouse or other financially responsible family member living in the same household.

(b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;

(c) Is a currently disabled client receiving widow's or widower's benefits under section 202 (e) or (f) of the SSA if the disabled client:

(i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983; and

(ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202 (e) or (f) of the SSA for January 1984;

(iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the client;

(iv) Has been continuously entitled to a widow's or widower's benefit under section 202 (e) or (f) of the SSA;

(v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;

(vi) Is fifty through fifty-nine years of age; and

(vii) Filed an application for medicaid coverage before July 1, 1988.

(d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202 (e) or (f) of the SSA if the person:

(i) Is not eligible for the hospital insurance benefits under medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202 (e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind client receiving Title II Disabled Adult Childhood (DAC) benefits under section 202(d) of the SSA if the client:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under section 202(d) of the DAC and any subsequent COLA increases provided under section 215(i) of the SSA were disregarded.

(f) Is a client who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD); and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible for OAA, AB, AFDC, SSI, or APRD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for MN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0070, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the state-funded general assistance - expedited medicaid disability (GA-X) program when they:

(a) Meet the requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(b) Meet the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues.

Clients may be eligible for GA cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the person is eligible for GAU or ADATSA program coverage as described in WAC 388-400-0025 and 388-800-0048. GAU clients residing in counties designated as mandatory managed care plan counties must enroll in a plan, pursuant to WAC 388-538-063.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). 04-15-003, § 388-505-0110, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350 and 388-503-0370.]

WAC 388-505-0210 Children's healthcare programs. Funding for children's healthcare coverage may come through Title XIX (medicaid) or Title XXI for the Social Security Act (SCHIP), or through state-funded programs. There are no resource limits for children's medical programs, but children must meet the eligibility criteria below to qualify for these programs.

(1) Newborns are eligible for federally matched categorically needy (CN) coverage through their first birthday when:

(a) The child's mother was eligible for and receiving medical assistance at the time of the child's birth; and

(b) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen who are U.S. citizens, U.S. nationals, or qualified aliens as described in WAC 388-424-0001 and 388-424-0006 (1) and (4) are eligible for federally matched CN coverage under children's healthcare programs when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) A Social Security number or application as described in chapter 388-476 WAC;

(c) Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005(11);

(d) Family income is at or below two hundred percent federal poverty level (FPL), as described in WAC 388-478-0075 at each application or review; or

(e) They received supplemental security income (SSI) cash payments in August 1996 and would continue to be eligible for those payments except for the August 1996 passage of amendments to federal disability definitions; or

(f) They are eligible for SSI-related CN or MN coverage.

(3) Noncitizen children under the age of nineteen, who do not meet qualified alien status as described in WAC 388-424-0006 (1) or (4), or are ineligible due to the five-year ban as described in WAC 388-424-0006(3), are eligible for state-funded CN coverage under children's healthcare programs when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC; and

(b) Family income is at or below two hundred percent FPL at each application or review.

(4) Children under the age of nineteen are eligible for premium-based CN coverage under children's healthcare programs as described in chapter 388-542 WAC when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) Family income is over two hundred percent FPL, as described in WAC 388-478-0075, but not over two hundred fifty percent FPL at each application or review;

(c) They do not have other creditable health insurance as described in WAC 388-542-0050; and

(d) They pay the required monthly premiums as described in WAC 388-505-0211

(5) Children under age nineteen are eligible for the medically needy (MN) medicaid program when they meet:

(a) Citizenship or immigrant status, state residence, and Social Security number requirements as described in subsection (2)(a), (b), and (c); and

(b) They are ineligible for other federal medicaid programs; and

(c) Meet their spenddown obligation as described in WAC 388-519-0100 and 388-519-0110.

(6) Children under the age of twenty-one who reside or expect to reside in a medical institution, intermediate care facility for the mentally retarded (ICF/MR), hospice care center, nursing home, or psychiatric facility may be eligible for medical coverage. See WAC 388-505-0230 "Family related

institutional medical" and WAC 388-513-1320 "Determining institutional status for long-term care."

(7) Children who are in foster care under the legal responsibility of the state, or a federally recognized tribe located within the state, are eligible for federally matched CN medicaid coverage through the month of their:

(a) Eighteenth birthday;

(b) Twenty-first birthday if children's administration determines they remain eligible for continued foster care services; or

(c) Twenty-first birthday if they were in foster care on their eighteenth birthday and that birthday was on or after July 22, 2007.

(8) Children who receive subsidized adoption services are eligible for federally matched CN medicaid coverage.

(9) Children under age of nineteen may also be eligible for:

(a) Family medical as described in WAC 388-505-0220;

(b) Medical extensions as described in WAC 388-523-0100; or

(c) SSI-related MN if they:

(i) Meet the blind and/or disability criteria of the federal SSI program, or the condition of subsection (2)(e); and

(ii) Have countable income above the level described in WAC 388-478-0070(1).

(10) Children who are ineligible for other children's healthcare programs due to citizenship or immigrant status requirements may be eligible for the alien emergency medical program (AEM) if they meet the following criteria:

(a) They have a documented emergent medical condition as defined in WAC 388-500-0005;

(b) They meet the other AEM program requirements as described in WAC 388-438-0110; and

(c) They have income that exceeds children's healthcare program standards; or

(d) They are disqualified from receiving premium-based children's healthcare coverage as described in subsection (4) of this section because of creditable coverage or nonpayment of premiums.

(11) Except for a client described in subsection (6), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for children's healthcare programs.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-505-0210, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-505-0210, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-505-0210, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.050. 03-14-107, § 388-505-0210, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0210, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0210, filed 5/21/01, effective 6/21/01. Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-505-0210, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0905, 388-509-0910 and 388-509-0920.]

WAC 388-505-0211 Premium requirements for premium-based children's healthcare programs. (1) For the purposes of this chapter, **"premium"** means an amount paid for medical coverage.

(2) Payment of a premium is required as a condition of eligibility for premium-based children's healthcare coverage, as described in WAC 388-505-0210(4), unless the child is:

(a) Pregnant; or

(b) An American Indian or Alaska native.

(3) The premium requirement begins the first of the month following the determination of eligibility. There is no premium requirement for medical coverage received in a month or months before the determination of eligibility.

(4) The premium amount for the assistance unit is based on the net available income as described in WAC 388-450-0005. If the household includes more than one assistance unit, the premium amount billed for the assistance units may be different amounts.

(5) The premium amount for each eligible child is fifteen dollars per month per child, up to a maximum of forty-five dollars per month, per household.

(6) All children in an assistance unit are ineligible for medical coverage when the head of household fails to pay required premium payments for three consecutive months.

(7) When the department terminates the medical coverage of a child due to nonpayment of premiums, the child has a three-month period of ineligibility beginning the first of the following month. The three-month period of ineligibility is rescinded only when the:

(a) Past due premiums are paid in full prior to the begin date of the period of ineligibility; or

(b) The child becomes eligible for a nonpremium-based medical program. The department will not rescind the three-month period of ineligibility for reasons other than the criteria described in this subsection.

(8) The department writes off past-due premiums after twelve months.

(9) When the designated three-month period of ineligibility is over, all past due premiums that are an obligation of the head of household must be paid or written off before a child can become eligible for premium-based children's healthcare.

(10) A family cannot designate partial payment of the billed premium amount as payment for a specific child in the assistance unit. The full premium amount is the obligation of the head of household of the assistance unit. A family can decide to request medical coverage only for certain children in the assistance unit, if they want to reduce premium obligation.

(11) A change that affects the premium amount is effective the month after the change is reported and processed.

(12) A sponsor or other third party may pay the premium on behalf of the child or children in the assistance unit. The premium payment requirement remains the obligation of head of household of the assistance unit. The failure of a sponsor or other third party to pay the premium does not eliminate the:

(a) Establishment of the period of ineligibility described in subsection (7) of this section; or

(b) Obligation of the head of household to pay past-due premiums.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-505-0211, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-505-0211, filed 7/30/04, effec-

tive 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.055, 2004 c 276. 04-08-125, § 388-505-0211, filed 4/7/04, effective 5/8/04.]

WAC 388-505-0220 Family medical eligibility. (1) A person is eligible for categorically needy (CN) medical assistance when they are:

(a) Receiving temporary assistance for needy families (TANF) cash benefits;

(b) Receiving Tribal TANF;

(c) Receiving cash diversion assistance, except SFA relatable families, described in WAC 388-400-0010(2);

(d) Eligible for TANF cash benefits but choose not to receive; or

(e) Not eligible for or receiving TANF cash assistance, but meet the eligibility criteria for aid to families with dependent children (AFDC) in effect on July 16, 1996 except that:

(i) Earned income is treated as described in WAC 388-450-0210; and

(ii) Resources are treated as described in WAC 388-470-0005 for applicants and 388-470-0026 for recipients.

(2) An adult cannot receive a family medicaid program unless the household includes a child who is eligible for:

(a) Family medicaid;

(b) SSI; or

(c) Children's medicaid.

(3) A person is eligible for CN family medical coverage when the person is not eligible for or receiving cash benefits solely because the person:

(a) Received sixty months of TANF cash benefits or is a member of an assistance unit which has received sixty months of TANF cash benefits;

(b) Failed to meet the school attendance requirement in chapter 388-400 WAC;

(c) Is an unmarried minor parent who is not in a department-approved living situation;

(d) Is a parent or caretaker relative who fails to notify the department within five days of the date the child leaves the home and the child's absence will exceed one hundred eighty days;

(e) Is a fleeing felon or fleeing to avoid prosecution for a felony charge, or is a probation and parole violator;

(f) Was convicted of a drug related felony;

(g) Was convicted of receiving benefits unlawfully;

(h) Was convicted of misrepresenting residence to obtain assistance in two or more states;

(i) Has gross earnings exceeding the TANF gross income level; or

(j) Is not cooperating with WorkFirst requirements.

(4) An adult must cooperate with the division of child support in the identification, use, and collection of medical support from responsible third parties, unless the person meets the medical exemption criteria described in WAC 388-505-0540 or the medical good cause criteria described in chapter 388-422 WAC.

(5) Except for a client described in WAC 388-505-0210(6), a person who is an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 08-19-099 and 08-20-014, § 388-505-0220, filed 9/17/08 and 9/18/08, effective 10/18/08 and 10/19/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-14-105, § 388-505-0220, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-16-127, § 388-505-0220, filed 8/3/05, effective 9/3/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0220, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0220, filed 5/21/01, effective 6/21/01; 98-16-044, § 388-505-0220, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0740 and 388-522-2210.]

WAC 388-505-0540 Assignment of rights and cooperation. (1) When a person becomes eligible for any of the department's medical programs, they make assignment of certain rights to the state of Washington. This assignment includes all rights to any type of coverage or payment for medical care which results from:

(a) A court order;

(b) An administrative agency order; or

(c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC 388-501-0100).

(2) **Subrogation** is a legal term which describes the method by which the state acquires the rights of a client for whom or to whom the state has paid benefits. The subrogation rights of the state are limited to the recovery of its own costs.

(3) The person who signs the application makes the assignment of rights to the state. Assignment is made on their own behalf and on behalf of any eligible person for whom they can legally make such assignment.

(4) A person must cooperate with the department in the identification, use or collection of third-party benefits. Failure to cooperate results in a termination of eligibility for the responsible person. Other obligations for cooperation are located in chapters 388-14A and 388-422 WAC. The following clients are exempt from termination of eligibility for medical coverage as a result of noncooperation:

(a) A pregnant woman, and

(b) Minor children, and

(c) A person who has been determined to have "good cause" for noncooperation (see WAC 388-422-0015).

(5) A person will not lose eligibility for medical assistance programs due solely to the noncooperation of any third party.

(6) A person will be responsible for the costs of otherwise covered medical services if:

(a) The person received and kept the third-party payment for those services; or

(b) The person refused to provide to the provider of care their legal signature on insurance forms.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-505-0540, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0540, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-505-0540, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0540, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-012, 388-501-0170 and 388-505-0560.]

Chapter 388-506 WAC
MEDICAL FINANCIAL RESPONSIBILITY

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-506-0610 AFDC-related medical programs. [Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-506-0610, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 95-10-025 (Order 3847), § 388-506-0610, filed 4/26/95, effective 5/27/95; 94-17-034 (Order 3767), § 388-506-0610, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-506-0610, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-046 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055, 388-450-0005 and 388-470-0070.

388-506-0630 SSI-related income deeming. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-506-0630, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0630, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-027 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055 and 388-450-0150.

WAC 388-506-0620 SSI-related medical clients. (1) The department shall consider income and resources for an institutionalized:

(a) Child as described under WAC 388-513-1315(6); or

(b) Spouse as described under WAC 388-513-1330 and 388-513-1350.

(2) The department shall consider the income and resources of spouses as available to each other through the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(3) The department shall follow WAC 388-515-1505, 388-515-1510, or 388-515-1530 when one or both spouses are receiving community options program entry system (COPES), community alternatives program (CAP), outward bound residential alternatives (OBRA), or coordinated community aids service alternatives (CASA) waivered service program.

(4) The department shall allow a community spouse applying for medically needy a spousal deduction equal to the one-person medically needy income level (MNIL) less the spouse's income when:

(a) The community spouse is living in the same household as the spouse; and

(b) The spouse is receiving home-based and community-based services.

(5) The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when:

(a) Only one spouse enters the facility;

(b) Both spouses enter the same facility but have separate rooms; or

(c) Both spouses enter separate facilities.

(6) The department shall consider income and resources jointly when spouses are placed in a CCF, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(7) See Wac 388-408-0055 for rules on medical assistance units that include SSI-related persons.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-506-0620, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0620, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-025.]

Chapter 388-512 WAC
SSI-RELATED GRANDFATHERED RECIPIENTS

WAC

388-512-1210 Program description.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-512-1215 General eligibility. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1215, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-015.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1220 Eligibility—Blindness. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-020.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1225 Permanently and totally disabled. [Statutory Authority: RCW 74.08.090. 95-02-025 (Order 3816), § 388-512-1225, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-512-1225, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-025.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1230 Refusal to accept medical treatment. [Statutory Authority: RCW 74.08.090. 01-02-076, § 388-512-1230, filed 12/29/00, effective 1/29/01; 94-10-065 (Order 3732), § 388-512-1230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-030.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1235 Review for disability or blindness. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1235, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-035.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1240 Computation of available income. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1240, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-040.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1245 Monthly maintenance standard—Own home. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1245, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-045.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1250 Monthly maintenance standard—Person in institution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-050.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1255 Available income and nonexempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1255, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-055.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1260 Exempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1260, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-060.]

Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1265 Nonexempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1265, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-065.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.-090, and 74.09.055.

388-512-1275 Continuing certification. [Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-512-1275, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1275, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-075.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.

388-512-1280 Application following termination. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1280, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-080.] Repealed by 98-04-004, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.04.-050, 74.08.090 and 74.09.510.

WAC 388-512-1210 Program description. The department shall provide medical assistance within limitations set forth in these rules and regulations to a person who is a grandfathered client.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-010.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-513-1300 Applicability of alternate living and institutional rules. [Statutory Authority: RCW 74.08.090. 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. 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.

388-513-1310 Resource standard—Institutional. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. 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.

388-513-1360 Determining excluded resources for long-term care (LTC) services. [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, § 388-513-1360, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1360, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.] Repealed by 07-01-073, 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, 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).

WAC 388-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Add-on hours" means additional hours the department purchases from providers to perform medically oriented tasks for clients who require extra help because of a handicapping condition.

"Alternate living facility (ALF)" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

(3) Adult residential rehabilitation center (ARRC) or adult residential treatment facility (ARTF), a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

(5) Division of developmental disabilities (DDD) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

"Clothing and personal incidentals (CPI)" means the same as personal needs allowance (PNA) which is defined later in this section.

"Community options program entry system (COPES)" means a medicaid waiver program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

"Community spouse (CS)" means a person who does not live in a medical institution or nursing facility, and who is legally married to an institutionalized client or to a person receiving services from home and community-based waiver programs.

"Comprehensive assessment (CA)" means the evaluation process used by a department designated social services worker to determine the client's need for long-term care services.

"DDD waiver" means medicaid waiver programs that provide home and community-based services as an alternative to an intermediate care facility for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD. There are four waivers administered by DDD: Basic, Basic Plus, Core and Community Protection.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

"Federal benefit rate (FBR)" means the basic benefit amount the social security administration (SSA) pays to clients who are eligible for the supplemental security income (SSI) program.

"Institutional services" means services paid for by medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"Institutional status" means what is described in WAC 388-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC 388-513-1320.

"Institutionalized spouse" means a client who has attained institutional status as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"Medically intensive children (MIC)" program means a medicaid waiver program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"Noninstitutional medical assistance" means medical benefits provided by medicaid or state-funded programs that do not include LTC services.

"Nursing facility turnaround document (TAD)" means the billing document nursing facilities use to request payment for institutionalized clients.

"Outward bound residential alternative (OBRA)" means a medicaid waiver program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"Participation" means the amount a client is responsible to pay each month toward the total cost of care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPI."

"Prouty benefits" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"Short stay" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Swing bed" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"Transfer of a resource or asset" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount; or

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under medicaid. In Washington state, waiver programs are DDD waivers, COPES, MIC, and OBRA.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276. 04-18-054, § 388-513-1301, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 02-09-052, § 388-513-1301, filed 4/12/02, effective 5/13/02. 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, § 388-513-1301, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0045.

(5) The department determines a client's nonexcluded resources for noninstitutional medical assistance under the:

(a) General assistance (GA) and temporary assistance for needy families (TANF) programs as described in chapter 388-470 WAC; and

(b) SSI-related medical program as described in chapter 388-475 WAC.

(6) The department determines a client's nonexcluded income for noninstitutional medical assistance as described in:

(a) Chapter 388-450 WAC for GA and TANF programs; and

(b) Chapter 388-475 WAC and WAC 388-506-0620 for SSI-related medical programs.

(7) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-475-0050, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA and TANF noninstitutional medical assistance for a period of months described in chapter 388-416 WAC.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

[Statutory Authority: RCW 74.08.090. 06-07-077, § 388-513-1305, 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, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

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 388-513-1320 Determining institutional status for long-term care (LTC) services. Institutional status is an eligibility requirement for LTC services.

(1) To attain institutional status, a client must:

(a) Be approved for and receiving waiver or hospice services; or

(b) Reside or be likely to reside in a medical facility for a continuous period of:

(i) Ninety days for a child seventeen years of age or younger receiving inpatient chemical dependency and/or inpatient mental health treatment; or

(ii) Thirty days for:

(A) An SSI-related client;

(B) A child not described in subsection (1)(b)(i); or

(C) A client related to medical eligibility as described in WAC 388-513-1315 (10) or (11).

(2) A client's institutional status is not affected by a:

(a) Transfer between medical facilities; or

(b) Change from one kind of long-term care services to another.

(3) A client loses institutional status when the client:

(a) Is absent from the medical facility for at least thirty consecutive days; or

(b) Does not receive waiver or hospice services for at least thirty consecutive days.

[Statutory Authority: RCW 74.08.090. 06-07-077, § 388-513-1320, 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, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, 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 388-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exceptions described in subsections (30) and (33).

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC);

(3) Native American benefits excluded by federal statute (refer to WAC 388-450-0040);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental Security Income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution;

(10) Child support payments received from an absent parent for a minor child who is not institutionalized;

(11) The amount of expenses related to impairments of a permanently and totally disabled client that allow the client to work;

(12) The amount of expenses related to blindness that allow the client to work;

(13) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(14) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(15) Assistance (other than wages or salary) received under the Older Americans Act;

(16) Assistance (other than wages or salary) received under the foster grandparent program;

(17) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(18) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(19) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(20) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(21) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(22) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(23) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(24) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(25) Payments made from *Susan Walker v. Bayer Corporation, et, al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(26) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(27) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(28) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(29) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(30) Interest earned from payments described in subsections (24) through (29) is considered available and counted as nonexcluded income;

(31) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(32) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent;

(b) Unusual medical expenses, aid and attendance allowance, and housebound allowance, with the exception described in subsection (33);

(33) Benefits described in subsection (32)(b) for a client who resides in a state veterans' home and has no dependents are excluded when determining eligibility, but are considered available when determining participation in the cost of care.

[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, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the Supplemental Security Income (SSI) program as described in WAC 388-475-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC 388-513-1340, plus one-half of the remainder.

(3) For a TANF/SFA-related client, fifty percent of gross earned income.

(4) Department of Veterans Affairs benefits if:

(a) Those benefits are designated for:

(i) Unusual medical expenses;

(ii) Aid and attendance allowance; or

(iii) Housebound allowance; and

(b) The client:

(i) Resides in a state veterans' home; and

(ii) Has no dependents.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

[Statutory Authority: RCW 74.08.090. 06-07-077, § 388-513-1345, filed 3/13/06, effective 4/13/06. 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, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

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) A vehicle 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 an 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 federal benefit rate (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. Effective January 1, 2008, the maximum allocation is one hundred and four thousand four hundred dollars. This standard increases annually on January 1st based on the consumer price index. (For the current standard starting January 2008 and each year thereafter, see long-term care standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml); 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. For the current standard starting July 2007 and each year thereafter, see long-term care standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(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, 74.09.500, and 74.09.530. 08-13-072, § 388-513-1350, filed 6/16/08, effective 7/17/08. 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)(b) or (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)(b) or (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)(b) or (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 388-475-0050 (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 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-513-1363, filed 5/15/08, effective 6/15/08. 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 388-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003. Refer to WAC 388-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in subsection (1)(d);

(c) The transfer of an asset 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;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(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)(b) or (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 client 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 transfer of an asset, if the transfer meets the conditions described in subsection (4), 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 client's child who meets the disability criteria described in WAC 388-475-0050 (1)(b) or (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 388-475-0050 (1)(b) or (c); or

(f) 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)(b) or (c).

(2) 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 institutional status, 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 waivered 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.

(3) 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 (2) as the transfer of an asset without adequate consideration.

(4) 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)(e), 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 or the trust, whichever is less; and

(d) The requirements in subsection (4)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC 388-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) 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.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in subsection (5)(a)(ii).

(6) 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 (6)(a) becomes an available resource as of the first day of the following month.

(7) 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).

(8) 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 (8)(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 (5)(a) and (b) and (8)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) 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.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-513-1364, filed 5/15/08, effective 6/15/08.

Statutory Authority: RCW 74.08.090. 03-20-059, § 388-513-1364, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-06-048, § 388-513-1364, filed 2/28/03, effective 4/1/03.]

WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997 and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997. Refer to WAC 388-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003. Refer to WAC 388-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(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)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A 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 transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or 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 the client's child who meets the disability criteria described in WAC 388-475-0050 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-fours years old or younger and meets the disability criteria described in WAC 388-475-0050 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-561-0100.

(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 client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997 and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) 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 remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) 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).

(9) 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 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 (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) 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.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-513-1365, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-14-038, § 388-513-1365, filed 6/23/03, effective 8/1/03. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-513-1365, filed 12/29/00, effective 1/29/01. 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, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC 388-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993 and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

[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, § 388-513-1366, filed 12/8/99, effective 1/8/00.]

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 depart-

ment 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 noninstitutional 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 through June 30, 2008 fifty-five dollars and forty-five cents for all other clients in a medical institution. Effective July 1, 2008 this PNA increases to fifty-seven dollars and twenty-eight cents.

(v) Current PNA and long-term care standards can be found at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(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 388-475-0050(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, 2008, two thousand six hundred ten 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/). Starting January 1, 2008 and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml. 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 hearings 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.

(9) Standards described in this section for long-term care can be found at: http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. 08-13-072, § 388-513-1380, filed 6/16/08, effective 7/17/08. 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)(l)(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.]

WAC 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility. This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.

(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:

(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or

(b) The facility is unable to fulfill the terms of the contract and has:

(i) Voided the contract; and

(ii) Refunded any of the client's existing assets to the client.

(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:

(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and

(b) Surrenders income and/or resources to the organization in exchange for such benefits.

[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, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-515-1530 Coordinated community AIDS services alternatives (CASA) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1530, filed 12/28/00, effective 1/28/01. 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, § 388-515-1530, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1530, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.] Repealed by 03-08-067, filed 3/31/03, effective 5/1/03. Statutory Authority: RCW 74.08.090, 34.05.353 (2)(c).

WAC 388-515-1505 Long-term care home and community based services and hospice. (1) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) services administered by home and community services (HCS) and hospice services administered by health and recovery services administration (HRSA).

(2) The HCB service programs are:

(a) Community options program entry system (COPES);

(b) Program of all-inclusive care for the elderly (PACE);

(c) Washington medicaid integration partnership (WMIP); or

(d) New Freedom consumer directed services (New Freedom).

(3) Roads to community living (RCL) services. For RCL services this chapter is used only to determine your cost of care. Medicaid eligibility is guaranteed for three hundred sixty-five days upon discharge from a medical institution.

(4) Hospice services if you don't reside in a medical institution and:

(a) Have gross income at or below the special income level (SIL); and

(b) Aren't eligible for another CN or medically needy (MN) medicaid program.

(5) WAC 388-515-1506 describes the general eligibility requirements for HCS CN waivers.

(6) WAC 388-515-1507 describes eligibility for waiver services when you are eligible for medicaid using noninstitutional CN rules.

(7) WAC 388-515-1508 describes the initial financial eligibility requirements for waiver services when you are not eligible for noninstitutional CN medicaid described in WAC 388-515-1507(1).

(8) WAC 388-515-1509 describes the rules used to determine your responsibility in the cost of care for waiver services if you are not eligible for medicaid under a CN program listed in WAC 388-515-1507(1). This is also called client participation or post eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1505, filed 11/3/08, effective 12/4/08. 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 388-515-1506 What are the general eligibility requirements for home and community based (HCB) services and hospice? (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter 388-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the Supplemental Security Income (SSI) program as described in WAC 388-475-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC 388-500-0005, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in subsection (1)(a);

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in subsection (1)(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 through 388-513-1366;

(i) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(2) Refer to WAC 388-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1506, filed 11/3/08, effective 12/4/08.]

WAC 388-515-1507 What are the financial requirements for home and community based (HCB) services when you are eligible for a noninstitutional categorically needy (CN) medicaid program? (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental Security Income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 388-475-0100 (2)(a) and (b);

(c) General assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6) and are receiving CN medicaid.

(2) You are not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1366. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(7) If you are eligible for general assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6), you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the general assistance program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and general assistance grant to the facility for the cost of room and board up to the ADSA room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents, which you keep for your PNA.

(8) Current resource and income standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1507, filed 11/3/08, effective 12/4/08.]

WAC 388-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)? (1) If you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC 388-513-1315 and 388-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC 388-513-1350.

(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 (d), (e) and (f) if you verify these expenses.

(4) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR).

(5) The department follows the rules in WAC 388-515-1325, 388-513-1330, and 388-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL and FBR) for long-term care are found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1508, filed 11/3/08, effective 12/4/08.]

WAC 388-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC 388-515-1508? If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the medically needy income level (MNIL) for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ADSA room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income.

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that you make your income available to your 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 1 (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 your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, minus;

(V) The food assistance standard utility allowance (SUA) (for long-term care services this is set at the standard utility allowance for a four-person household), provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) 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 1 (http://aspe.os.dhhs.gov/poverty).

(e) Is reduced by your community spouse's gross countable income.

(f) The amount allocated to the community spouse may be greater than the amount in subsection (d)(ii) only when:

(i) There is a court order approving the higher amount for the support of your community spouse; or

(ii) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(g) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutional spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, the amount is equal to one-third of the community spouse allocation as described in WAC 388-513-1380 (5)(b)(i)(A) that exceeds the dependent family member's income (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(h) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(i) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2) and (3)(a) and (b); and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (4)(a); and

(iii) Guardianship fees and administrative costs in subsection (4)(b).

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 388-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1509, filed 11/3/08, effective 12/4/08.]

WAC 388-515-1510 Division of developmental disabilities (DDD) home and community based services waivers. The four sections that follow describe the general and financial eligibility requirements for the division of developmental disabilities (DDD) home and community based services (HCBS) waivers.

(1) WAC 388-515-1511 describes the general eligibility requirements under the four DDD HCBS waivers.

(2) WAC 388-515-1512 describes the financial requirements if you are eligible for medicaid under the noninstitutional categorically needy program (CN-P).

(3) WAC 388-515-1513 describes the initial financial requirements if you are not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1).

(4) WAC 388-515-1514 describes the post eligibility financial requirements if you are not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1510, filed 5/20/08, effective 6/20/08. Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276. 04-18-054, § 388-515-1510, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1510, filed 12/28/00, effective 1/28/01. 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, § 388-515-1510, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1510, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

WAC 388-515-1511 What are the general eligibility requirements for waiver services under the four division of developmental disabilities (DDD) home and community based services (HCBS) waivers? This section describes

the general eligibility requirements for waiver services under the four DDD home and community based services (HCBS) waivers.

(1) The four DDD HCBS waivers are:

(a) Basic;

(b) Basic plus;

(c) Core; and

(d) Community protection.

(2) The requirements for services for DDD HCBS waivers are described in chapter 388-845 WAC. The department establishes eligibility for DDD HCBS waivers. To be eligible, you must:

(a) Be an eligible client of the division of developmental disabilities (DDD);

(b) Meet the disability criteria for the Supplemental Security Income (SSI) program as described in WAC 388-475-0050;

(c) Require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR);

(d) Have attained institutional status as described in WAC 388-513-1320;

(e) Be able to reside in the community and choose to do so as an alternative to living in an ICF/MR;

(f) Need waiver services as determined by your plan of care or individual support plan, and:

(i) Be able to live at home with waiver services; or

(ii) Live in a department contracted facility, which includes:

(A) A group home;

(B) Group training home;

(C) Child foster home, group home or staffed residential facility;

(D) Adult family home (AFH); or

(E) Adult residential care (ARC) facility.

(iii) Live in your own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider; and

(g) Be both medicaid eligible under the categorically needy program (CN-P) and be approved for services by the division of developmental disabilities.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1511, filed 5/20/08, effective 6/20/08.]

WAC 388-515-1512 What are the financial requirements if I am eligible for medicaid under the noninstitutional categorically needy program (CN-P)? (1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN-P) under one of the following programs:

(a) Supplemental Security Income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status. These clients have medicaid eligibility determined and maintained by the Social Security Administration;

(b) Healthcare for workers with disabilities (HWD) described in WAC 388-475-1000 through 388-475-1250;

(c) SSI-related CN-P medicaid described in WAC 388-475-0100 (2)(a) and (b) or meets the requirements in WAC 388-475-0880 and is CN-P eligible after the income disregards have been applied;

(d) CN-P medicaid for a child as described in WAC 388-505-0210 (1), (2), (7) or (8); or

(e) General assistance expedited medicaid disability (GA-X) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6).

(2) If you are eligible for a CN-P medicaid program listed in subsection (1) above, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services.

(3) If you are eligible for a CN-P medicaid program listed in subsection (1) above, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN-P medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1505. Room and board and long-term care standards are located at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(a) If you live in an ARC, AFH or DDD group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ADSA room and board standard. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for a premium based medicaid program such as healthcare for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN-P program.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. 08-24-069, § 388-515-1512, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.-500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1512, filed 5/20/08, effective 6/20/08.]

WAC 388-515-1513 How does the department determine if I am financially eligible for medical coverage if I am not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC 388-515-1514. To qualify, you must meet both the resource and income requirements.

(1) If you have resources which are higher than the standard allowed under WAC 388-515-1350, we may reduce the amount we are required to count if you have unpaid medical expenses.

(a) We will reduce your resources in an amount equal to the unpaid medical expenses you verify. The anticipated cost of your waiver services cannot be used as a medical expense to qualify for this deduction.

(b) If your remaining resources, after the deduction in section (1)(a) are still over the standard, you are ineligible until your resources are below the standard.

(c) You are not subject to a transfer of asset penalty described in WAC 388-513-1363 through 388-513-1366.

(d) Equity in your home is five hundred thousand dollars or less as described in WAC 388-513-1350.

(2) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC 388-515-1325, 388-513-1330 and 388-513-1340 to determine available income and income exclusions.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1513, filed 5/20/08, effective 6/20/08.]

WAC 388-515-1514 How does the department determine how much of my income I must pay towards the cost of my care if I am not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512 (1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or DDD group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ADSA room and board rate described in http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(3) Income that remains after the allocation described in (2) above, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished from your income or withheld according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that your income is made available to your 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 your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative minus;

(V) The food assistance standard utility allowance (for long term care 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, minus;

(VI) 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 your community spouse's gross countable income.

(iii) May be greater than the amount in subsection (d)(ii) only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, the amount is equal to one-third of the community spouse allocation as described in WAC 388-513-1380 (5)(b)(i)(A) that exceeds the dependent family member's income (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) for in home or subsection (2)(a) in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (3)(a); and

(iii) Guardianship fees and administrative costs in subsection (3)(b).

(4) If you are eligible for general assistance expedited medicaid disability (GA-X) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6), you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the general assistance program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and general assistance grant to the facility for the cost of room and board up to the ADSA room and board standard described in http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; or

(c) When you live in an ARC or DDD group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) The combination of the room and board amount and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or DDD group home provider.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. 08-24-069, § 388-515-1514, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.-500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1514, filed 5/20/08, effective 6/20/08.]

WAC 388-515-1540 Medically needy residential waiver (MNRW) effective March 17, 2003. This section describes the financial eligibility requirements for waiver services under the medically needy residential waiver (MNRW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNRW, a client must meet the following conditions:

(a) Does not meet financial eligibility for medicaid personal care or the COPES program;

(b) Is eighteen years of age or older;

(c) Meets the SSI related criteria described in WAC 388-475-0050;

(d) Requires 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 388-106-0400, would 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) Has attained institutional status as described in WAC 388-513-1320;

(g) Has been determined to be in need of waiver services as described in WAC 388-106-0410;

(h) Lives in one of the following department-contracted residential facilities:

(i) Licensed adult family home (AFH);

(ii) Assisted living (AL) facility; or

(iii) Enhanced adult residential care (EARC) facility.

(i) Is not 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) Meets the resource and income requirements described in subsections (2) through (6).

(2) The department determines a client's nonexcluded resources under MNRW as described in WAC 388-513-1350;

(3) Nonexcluded resources, after disregarding excess resources described in (4), must be at or below the resource standard described in WAC 388-513-1350 (1) and (2).

(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) Have not been used to satisfy a previous spend down liability;

(iii) Have not previously been used to reduce excess resources;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNRW 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.

(6) If the client's countable income is:

(a) Less than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW subject to availability per WAC 388-106-0435;

(b) More than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW when they meet the requirements described in subsections (7) through (9), subject to availability per WAC 388-106-0435.

(7) The portion of a client's countable income over the department-contracted rate is called "excess income."

(8) A client who meets the requirements for MNRW chooses a three or six month base period. The months must be consecutive calendar months.

(9) A client who has or will have "excess income" is not eligible for MNRW 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.

(10) Medical expenses described in subsection (4) of this WAC may be used to meet spenddown if not already used in subsection (4) of this WAC to disregard excess resources or to reduce countable income as described in subsection (5)(d).

(11) In cases where spenddown has been met, medical coverage begins the day services are authorized.

(12) 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) described in WAC 388-515-1505. (Long-term care standards can be found at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources described in WAC 388-513-1350;

(d) Incurred medical expenses described in (4) not used to meet spenddown or reduce excess resources described in WAC 388-513-1350.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-515-1540, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-515-1540, filed 5/17/05, effective 6/17/05. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-515-1540, filed 6/12/03, effective 7/13/03.]

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

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-517-1710 Medicare cost-sharing programs. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1710, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1710, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300.

388-517-1715 Qualified medicare beneficiary (QMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1715, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1715, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1715, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(1) and 388-517-0500(6).

388-517-1720 Qualified medicare beneficiaries—Income and resources. [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)(l)(m). 97-16-008, § 388-517-1720, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1720, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1720, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1730 Special low-income medicare beneficiaries (SLMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1730, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1730, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(2) and 388-517-0300(4).

388-517-1740 Special low-income medicare beneficiaries (SLMB)—Income and resources. [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)(l)(m). 97-16-008, § 388-517-1740, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1740, filed 7/10/96, effective 7/10/96; 95-23-030 (Order 3917, #100251), § 388-517-1740, filed 11/8/95, effective 12/9/95; 95-11-056 (Order 3848A), § 388-517-1740, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1750 Qualified disabled working individuals (QDWI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1750, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1750, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(6) and 388-478-0085.

388-517-1760 Qualified disabled working individuals (QDWI) income and resources. [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)(l)(m). 97-16-008, § 388-517-1760, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090. 96-15-029, § 388-517-1760, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1760, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1760, filed 5/3/94, effec-

tive 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.

388-517-1770 Qualified individuals (QI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1770, filed 5/19/98, effective 6/19/98.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(7) and 388-478-0085(5).

WAC 388-517-0300 Federal medicare savings and state-funded medicare buy-in programs. (1) Federal medicare savings and state-funded medicare buy-in programs help clients pay some of the costs that medicare does not cover under WAC 388-517-0320 (for program eligibility, see WAC 388-517-0310).

(2) The department offers the following medicare savings programs to eligible clients:

(a) Qualified medicare beneficiary (QMB);

(b) Specified low-income medicare beneficiary (SLMB);

(c) Qualified individual (QI-1); and

(d) Qualified disabled working individual (QDWI).

(3) The department offers the state-funded medicare buy-in program for clients who receive medicaid but do not qualify for the federal medicare savings programs.

[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, § 388-517-0300, filed 7/1/05, effective 8/1/05. Statutory Authority: RCW 74.08.090, 74.09.530. 02-11-074, § 388-517-0300, filed 5/13/02, effective 6/13/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-517-0300, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

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 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.

(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.]

WAC 388-517-0400 Medicare coinsurance payment—Extended care patient. The department will pay for a long-term care client's medicare coinsurance if the:

(1) Client is eligible for extended care medicare benefits;

(2) Client is eligible for medicaid, qualified medicare beneficiary (QMB) program, or the special low-income medicare beneficiary (SLMB) program; and

(3) Medicare coinsurance costs less than the medicaid nursing facility rate.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055. 01-06-033, § 388-517-0400, filed 3/2/01, effective 4/2/01.]

WAC 388-517-0500 State payment of medicare prescription drug copayments for full-benefit dual-eligible clients. This rule describes the conditions under which the department pays medicare prescription drug copayments for full-benefit dual-eligible clients.

(1) Definitions:

(a) "Medicare Part D copayment" - A flat dollar amount that a medicare beneficiary must pay toward the cost of each prescription drug received under the medicare prescription drug program.

(b) "Full-benefit, dual-eligible person" - Someone who receives medicaid services under the categorically needy (CN) or medically needy (MN) program and is a medicare beneficiary.

(2) The department pays a full-benefit dual-eligible client's medicare Part D copayment if:

(a) The copayment is for a prescription drug covered under the client's medicare Part D plan; and

(b) The copayment rate is not more than the federal low-income subsidy copayment rate for a medicare Part D covered drug; and

(c) The budget includes funding for medicare Part D copayments.

(3) Pharmacies bill the department directly for medicare Part D copayments for full-benefit, dual-eligible clients. The client is not responsible for copayments paid by the department as described in subsection (2) of this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2007 c 3. 08-15-055, § 388-517-0500, filed 7/14/08, effective 8/14/08.]

Chapter 388-519 WAC
SPENDDOWN

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-519-0120 Spenddown—Medically indigent program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.] Repealed by 04-20-045, filed 9/30/04, effective 10/31/04. Statutory Authority: RCW 74.08.090 and 34.05.353(2).

388-519-1905 Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.

388-519-1910 Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.

388-519-1930 Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.

388-519-1950 Institutional spenddown. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-519-0100 Eligibility for the medically needy program. (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when a person:

(a) Is not excluded under subsection (1) of this section; and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for medical services either paid or unpaid and incurred during the base period; or

(iii) Be for medical services paid and incurred during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in WAC 388-501-0060 and 388-501-0065, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses for services rendered to the client must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) The medical expenses applied to the spenddown amount are the client's financial obligation and are not reimbursed by the department (see WAC 388-502-0100).

(16) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a clients failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-519-0110, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-519-0110, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 05-08-093, § 388-519-0110, filed 4/1/05, effective 5/2/05; 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

Chapter 388-523 WAC
MEDICAL EXTENSIONS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-523-2305 Medical extensions. [Statutory Authority: RCW 74.04.-050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

388-523-2320 Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

WAC 388-523-0100 Medical extensions—Eligibility.

(1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for

extended medical benefits when they become ineligible for their current medical program because the family receives:

(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.

(2) A family is eligible to receive extended medical benefits beginning the month after termination from TANF cash or family medical program for:

(a) Four months for a family described in subsection (1)(a) of this section; or

(b) Up to twelve months, in two six-month segments, for a family described in subsection (1)(b) of this section. For the purposes of this chapter, months one through six are the initial six-month extension period. Months seven through twelve are the second six-month extension period.

(3) A family member is eligible to receive six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The individual family member:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution;

(iv) Leaves the household; or

(v) Does not cooperate, without good cause, with the division of child support or with third party liability requirements.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the department or the department does not know the whereabouts of the family; or

(iii) No longer includes a child as defined in WAC 388-404-0005(1).

(4) A family member is eligible to receive the second six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The family is no longer eligible for the reasons described in subsection (3)(a) or (b); or

(b) The individual family member is the caretaker adult who:

(i) Stops working or whose earned income stops;

(ii) Does not, without good cause, complete and return the completed medical extension report or otherwise provide the required income and child care information; or

(iii) Does not, without good cause, pay the billed premium amount for one month.

(5) A family described in subsection (3) will not receive medical extension benefits for any family member who has been found ineligible for TANF/SFA cash because of fraud in any of the six months prior to the medical extension period.

(6) For the purposes of this chapter, only individual family members that are eligible for medicaid are certified to receive medical benefits under this program.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-523-0100, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0100, filed 4/22/02, effective 5/23/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-523-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2210, 388-523-2305 and 388-523-2320.]

WAC 388-523-0110 Medical extensions—Reporting requirements. (1) The family must report family income and employment-related child care costs the family pays by the twenty-first day of:

(a) Month four of the extension period, for months one, two, and three; and

(b) Month seven of the extension period, for months four, five, and six.

(2) Circumstances may prevent a family from meeting the reporting requirements in subsection (1) of this section. The family remains eligible for the medical extension when good cause exists. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress;

(b) Lack of understanding the reporting requirement due to a language barrier;

(c) Transportation problems;

(d) Payment for work in each month of the reporting period was paid in a different month than it was earned;

(e) The client expected to be able to meet the family medical needs, but could not; or

(f) The client was given incorrect information about the reporting requirements. Refer to WAC 388-422-0020 (4) and (5).

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0110, filed 4/22/02, effective 5/23/02.]

WAC 388-523-0120 Medical extensions—Premiums. (1) **"Countable income"** means, for the purposes of determining the premium amount described in this chapter, all earned income of the adult family members, minus the amount of employment-related child care paid for by the family. The earned income of an adult, living in the household, who is financially responsible for other members of the assistance unit is included, whether or not the person is an eligible member of the assistance unit.

(2) The department requires the family to pay premiums for medical coverage provided during the second six-month medical extension period. The premium amount is one percent of the family's average countable income rounded down to the nearest whole dollar. This whole dollar amount is billed per adult per month. See subsection (3).

(3) The premiums for:

(a) Months seven, eight, and nine are based solely on the average countable income received in months one, two and three of the medical extension period; and

(b) Months ten, eleven, and twelve are based solely on the average countable income received in months four, five, and six of the medical extension period.

(4) A subsequent change in income does not effect the premium amount described in subsection (2) and (3) of this section.

(5) When a family's premium is one month in arrears, the family is ineligible for the balance of the medical extension period unless good cause exists. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress;

(b) Lack of understanding the premium payment requirement due to a language barrier;

(c) Transportation problems;

(d) Nonpayment of the premium because the client expected to be able to meet the family medical needs, but could not; or

(e) Receipt of incorrect information or nonreceipt of advance and adequate notice about the premium payment requirements. WAC 388-422-0020 (4) and (5) provisions regarding good cause rights and periodic review apply to good cause for nonpayment of premiums.

(6) The department exempts individual family members from premium payment requirements, as follows:

(a) Children;

(b) Pregnant women;

(c) American Indians and Alaska Natives; and

(d) Caretaker adults in a family whose countable income is equal to or less than one hundred percent of the federal poverty level based on family size as described in WAC 388-478-0075(2).

(7) When determining the exemption described in subsection (6)(b), the premium exemption is effective the first of the month following the client's report of the pregnancy to the department.

(8) When determining the exemption described in subsection (6)(d), the department shall include in the household size an unborn child and a person who is financially responsible for other members of the assistance unit, whether or not the person is an eligible member of the assistance unit. A person receiving SSI cash assistance is not included when determining the household size.

(9) The department determines a family's exemption from the premium requirement as described in subsection (6)(d) for:

(a) Months seven, eight and nine based solely on information available to the department at the time the premium for these months is calculated; and

(b) Months ten, eleven, and twelve based solely on information available to the department at the time the premium for these months is calculated.

(10) Any change resulting in an individual meeting the exemption criteria in subsection (6)(d) after the establishment of the premium amount for months seven, eight and nine is used to calculate the premium amount for months ten, eleven, and twelve. Any change resulting in an individual meeting the exemption criteria in subsection (6)(d) after the establishment of the premium amount for months ten, eleven, and twelve is not used to recalculate the premium amount for months ten, eleven, and twelve.

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 03-14-108, § 388-523-0120, filed 6/30/03, effective 6/30/03; 02-10-018, § 388-523-0120, filed 4/22/02, effective 5/23/02.]

WAC 388-523-0130 Medical extension—Redetermination. (1) When the department determines the family or an individual family member is ineligible during the medical extension period, the department must determine if they are eligible for another medical program.

(2) Children are eligible for twelve month continuous eligibility beginning with the first month of the medical extension period.

(3) When a family reports a reduction of income, the family may be eligible for a family medical program instead of medical extension benefits.

(4) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-523-0130, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0130, filed 4/22/02, effective 5/23/02.]

Chapter 388-526 WAC
MEDICAL FAIR HEARINGS

WAC

WAC 388-526-2610 Prehearing reviews for clients who request a fair hearing. (1) A client who does not agree with a department decision regarding medical or dental services has a right to a fair hearing under chapter 388-02 WAC.

(a) See chapter 388-538 WAC for hearing requests regarding managed care plans;

(b) See chapter 388-542 WAC for hearing requests regarding the children's health insurance program (CHIP);

(c) See WAC 388-502-0165 for requests for noncovered services.

(2) When a fair hearing is requested, either the client or MAA has the right to request and the client receive a medical assessment appropriate to the nature of the decision from one or more professionally qualified persons who are not a party to the action being appealed. WAC 388-538-120 applies to clients who are managed care enrollees.

(3) After receiving a request for a fair hearing, MAA may request additional information from the client, the provider, or the department. After MAA 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.

[Statutory Authority: RCW 74.08.090, 34.05.060. 00-21-062, § 388-526-2610, filed 10/16/00, effective 11/16/00. Statutory Authority: RCW 74.08.-090. 94-10-065 (Order 3732), § 388-526-2610, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-040.]

Chapter 388-527 WAC
ESTATE RECOVERY AND PRE DEATH LIENS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-527-2710 Recovery from estates. [Statutory Authority: RCW 74.08.090 and OBRA 1993, HB 2492. 94-17-035 (Order 3768), § 388-527-2710, filed 8/10/94, effective 9/10/94. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-047.] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

388-527-2720 Restitution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-050] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

388-527-2735 Liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2752 Deferring recovery. [Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2753 No liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.

388-527-2792 Interest assessed on past due debt. [Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2792, filed 4/30/04, effective 6/1/04.] Repealed by 06-17-075, filed 8/14/06, effective 9/14/06. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p.

388-527-2795 Serving notices on office of financial recovery (OFR). [Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2795, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2795, filed 5/18/99, effective 6/18/99.] Repealed by 06-17-075, filed 8/14/06, effective 9/14/06. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p.

WAC 388-527-2700 Purpose. This chapter describes the requirements, limitations, and procedures that apply when the department recovers the cost of medical care from the estate of a deceased client and when the department files liens prior to the client's death.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2700, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2700, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2700, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2730 Definitions. The following definitions apply to this chapter:

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian Health Service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Sec. 136.21(d) and 136.22.

"Estate" means all property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. The value of the estate will be reduced by any valid liability against the decedent's property at the time of death. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997 and before September 14, 2006, nonprobate assets as defined by RCW 11.02.005.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW 11.02.005 and any life estate interest held by the recipient immediately before death.

"Heir" means the decedent's surviving spouse and children (natural and adopted); or those persons who are entitled to inherit the decedent's property under a will properly executed under RCW 11.12.020 and accepted by the probate court as a valid will.

"Joint tenancy" means ownership of property held under circumstances that entitle one or more owners to the whole of the property on the death of the other owner(s), including, but not limited to, joint tenancy with right of survivorship.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services for clients of the home and community services division and division of developmental disabilities including, but not limited to, nursing facility care and home and community services.

"Medicaid" means the state and federally funded program that provides medical services under Title XIX of the Federal Social Security Act.

"Medical assistance" means both medicaid and medical care services.

"Medicare Savings programs" means the programs described in WAC 388-517-0300 that help a client pay some of the costs that medicare does not cover.

"Property": Examples include, but are not limited to, personal property, real property, title property, and trust property as described below:

(1) **"Personal property"** means any property that is not classified as real, title, or trust property in the definitions provided here;

(2) **"Qualified individual"** means an heir or an unmarried individual who, immediately prior to the client's death, was eighteen years of age or older, shared the same regular and permanent residence with the client and with whom the client had an exclusive relationship of mutual support, caring, and commitment.

(3) **"Real property"** means land and anything growing on, attached to, or erected thereon;

(4) **"Title property"** means, for the purposes of this chapter only, property with a title such as motor homes, mobile homes, boats, motorcycles, and vehicles.

(5) **"Trust property"** means any type of property interest titled in, or held by, a trustee for the benefit of another person or entity.

"State-only funded long-term care" means the long-term care services that are financed with state funds only.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2730, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2730, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2733 Estate liability. (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

(a) A surviving spouse; or

(b) A surviving child who was either:

(i) Under twenty-one years of age; or

(ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.005 is not liable for the cost of adult protective services (APS) financed with state funds only.

(4) The client's estate is not liable for amounts paid for medicare premiums and other cost-sharing expenses incurred on behalf of a client who is eligible only for the medicare savings programs, and not otherwise medicaid eligible.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2733, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2737 Deferring recovery. (1) For a client who died after June 30, 1994, the department defers recovery from the estate until:

(a) The death of the surviving spouse, if any; and

(b) There is no surviving child who is:

(i) Under twenty-one years of age, or

(ii) Blind or disabled as defined under chapter 388-511 WAC.

(2) The department may place a lien against property to evidence the department's right to recover after the deferral period specified in subsection (1) of this section.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2737, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2740 Age when recovery applies. The client's age and the date when services were received determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for medicaid services and subsection (2) covers liability for state-only funded long-term care services. An estate may be liable under both subsections.

(1) For a client who on July 1, 1994 was:

(a) Age sixty-five or older, the client's estate is liable for medicaid services that were subject to recovery and provided on and after the date the client became age sixty-five or after July 26, 1987, whichever is later;

(b) Age fifty-five through sixty-four years of age, the client's estate is liable for medicaid services that were subject to recovery and provided on and after July 1, 1994; or

(c) Under age fifty-five, the client's estate is liable for medicaid services that were subject to recovery and provided on and after the date the client became age fifty-five.

(2) Regardless of the client's age when the services were provided, the client's estate is liable for state-only funded long-term care services provided to:

(a) Home and community services' clients on and after July 1, 1995; and

(b) Division of developmental disabilities' clients on and after June 1, 2004.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2740, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2740, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2742 Services subject to recovery. The department considers the medical services the client received and the dates when the services were provided to the client, in order to determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for medicaid services and subsection (2) covers liability for state-only funded long-term care services. An estate can be liable under both subsections.

(1) The client's estate is liable for:

(a) All medicaid services provided from July 26, 1987 through June 30, 1994;

(b) The following medicaid services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medicaid services provided after June 30, 1995 and before June 1, 2004:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and disability services administration of the department; and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(d) The following services provided on and after June 1, 2004:

(i) All medicaid services;

(ii) Medicare savings programs services for individuals also receiving medicaid;

(iii) Medicare premiums only for individuals also receiving medicaid; and

(iv) Premium payments to managed care organizations.

(2) The client's estate is liable for all state-only funded long-term care services and related hospital and prescription drug services provided to:

(a) Home and community services' clients on and after July 1, 1995; and

(b) Division of developmental disabilities' clients on and after June 1, 2004.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2742, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2742, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2750 Delay of recovery for undue hardship. The department delays recovery under this section when the department determines that recovery would cause an undue hardship for a qualified individual(s). This delay is limited to the period during which the undue hardship exists. The undue hardship must exist at the time of the client's death in order to be considered for a delay of recovery.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more qualified individuals and income is limited; or

(b) Recovery would deprive a qualified individual of shelter and the qualified individual lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the decedent's cost of assistance would merely cause the qualified individual inconvenience or restrict his or her lifestyle; or

(b) The undue hardship was created as a result of estate planning methods by which the qualified individual or deceased client divested, transferred or otherwise encumbered assets, in whole or in part, to avoid recovery from the estate.

(3) When a delay in recovery is not granted, the department provides notice to the person who requested the delay of recovery. The department's notice includes information on how to request an administrative hearing to contest the department's denial.

(4) When a delay of recovery is granted, the department may revoke the delay of recovery if the qualified individual(s):

(a) Fails to supply timely information and resource declaration when requested by the department;

(b) Sells, transfers, or encumbers title to the property;

(c) Fails to reside full-time on the premises;

(d) Fails to pay property taxes and utilities when due;

(e) Fails to identify the state of Washington as the primary payee on the property insurance policies. The person granted the delay of recovery must provide the department with documentation of the coverage status on an annual basis.

(f) Have a change in circumstances under subsection (1) of this section for which the delay of recovery due to undue hardship was granted; or

(g) Dies.

(5) When a delay of recovery is granted due to undue hardship, the department has the option to:

(a) Apply a lien; and/or

(b) Accept a payment plan.

(6) A person may request an administrative hearing to contest the department's denial of delay of recovery due to undue hardship when that person suffered a loss because the delay was not granted.

(7) A request for an administrative hearing under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request for a delay of recovery due to an undue hardship;

(c) Include a copy of the department's denial;

(d) Be signed by the requester and include the requester's address and telephone number; and

(e) Be served, as described in WAC 388-527-2870, on the office of financial recovery (OFR) within twenty-eight calendar days of the date that the department sent the decision denying the request for a delay of recovery.

(8) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property and other assets of the time and place of the administrative hearing.

(9) An adjudicative proceeding held under this section is governed by chapters 34.05 RCW and 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.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2750, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2750, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2750, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2750, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2754 Assets not subject to recovery and other limits on recovery. (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

(i) No surviving spouse;

(ii) No surviving child who is:

(A) Under twenty-one years of age;

(B) Blind; or

(C) Disabled.

(iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsections (3) through (8) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a combined fair market value of two thousand dollars, is not recovered from the estate of the client:

(a) Family heirlooms;

(b) Collectibles;

(c) Antiques;

(d) Papers;

(e) Jewelry;

(f) Photos; and

(g) Other personal effects of the deceased client and to which a surviving child is entitled.

(4) Certain properties belonging to American Indians/Alaska Natives (AI/AN) are exempt from estate recovery if at the time of death:

(a) The deceased client was enrolled in a federally recognized tribe; and

(b) The estate or heir documents the deceased client's ownership interest in trust or nontrust real property and improvements located on a reservation, near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or located:

(i) Within the most recent boundaries of a prior federal reservation; or

(ii) Within the Contract Health Service Delivery Area boundary for social services provided by the deceased client's tribe to its enrolled members.

(5) Protection of trust and nontrust property under subsection (4) is limited to circumstances when the real property and improvements pass from an Indian (as defined in 25 U.S.C. Chapter 17, Sec. 1452(b)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and step-children, that their culture would nonetheless protect as family members, to a tribe or tribal organization and/or to one or more Indians.

(6) Certain AI/AN income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) are exempt from estate recovery by other laws and regulations.

(7) Ownership interests in or usage rights to items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

(8) Government reparation payments specifically excluded by federal law in determining eligibility are exempt from estate recovery as long as such funds have been kept segregated and not commingled with other countable resources and remain identifiable.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2754, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing liens. (1) The department files liens, seeks adjustments, and uses other means to recover the cost of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The probate estate's personal representative, if any;

(c) Any other person known to have title to the affected property and/or to the decedent's heir(s) as defined by WAC 388-527-2730; and

(d) The decedent's last known address or the address listed on the title, if any.

(3) The notice in subsection (2) of this section includes:

(a) The decedent's name, identification number, date of birth, and date of death;

(b) The amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client that the department seeks to recover;

(c) The department's intent to file a lien against the deceased client's property and other assets to recover the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client;

(d) The county in which the property and other assets are located; and

(e) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(4) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the decedent alleged by the department's notice is correct;

(b) Whether the decedent had legal title to the property; and

(c) Whether a lien is allowed under the provisions of Title 42 USC Section 1396p (a) and (b).

(5) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(6) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the

property and other assets of the time and place of the administrative hearing.

(7) An administrative hearing under this section is governed by chapters 34.05 RCW and 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) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the decedent's property and other assets if upheld by the final agency decision.

(9) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (2) of this section.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2790, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2790, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2790, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2810 Life estates and joint tenancy. (1) The department may enforce a lien authorized under this section against a decedent's life estate or joint tenancy interest in real property held by the decedent immediately prior to his or her death until the lien is satisfied. The department will not apply a lien against a decedent's life estate interest providing the decedent had not previously transferred an interest in the property while retaining a life estate.

(a) The value of the life estate subject to the lien is the fair market value of the decedent's interest in the property subject to the life estate immediately prior to death.

(b) The value of the joint tenancy interest subject to the lien is the value of the decedent's fractional interest he or she would have owned in the jointly held interest in the property had the decedent and the surviving joint tenants held title to the property as tenants in common immediately prior to death.

(2) The department's methodology for calculating the value of the life estate is determined using fair market value of the property. To determine the value of the life estate, the department multiplies the current fair market value of the property by the life estate factor in the life estate table. (The Centers for Medicare and Medicaid Services based table is found in the department's Eligibility A-Z Manual, Long Term Care, Appendix II and is available on-line at: http://www1.dshs.wa.gov/esa/eazmanual/.)

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2810, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2820 Liens prior to death. (1) Subject to the requirements of 42 USC Section 1396p and the conditions of this section, the department is authorized to file a lien against the property of a medical assistance client prior to his or her death, and to seek adjustment and recovery from the client's estate or sale of the property subject to the lien if:

(a) The client is permanently an inpatient in a nursing facility, intermediate care facility for individuals with mental retardation, or other medical institution as described in WAC 388-500-0005;

(b) The department determines, after notice and opportunity for a hearing, that the client cannot reasonably be expected to be discharged from the medical institution and return home; and

(c) None of the following are lawfully residing, in the client's home:

(i) The client's spouse;

(ii) The client's child who is under age twenty-one, or is blind or permanently and totally disabled as defined in Title 42 USC Section 1382c; or

(iii) A sibling of the client (who has an equity interest in such home and who was residing in the client's home for a period of at least one year immediately before the date of the client's admission to the medical institution).

(2) If the client is discharged from the medical facility and returns home, the department dissolves the lien.

(3) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The client's known address;

(c) Any other person known to have title to the affected property and the client's authorized representative, if any.

(4) The notice in subsection (3) of this section includes:

(a) The client's name, and the date the client began to receive services;

(b) The department's intent to file a lien against the client's property to recover the amount of medical assistance or state-only funded long-term care services, or both correctly paid on behalf of the client;

(c) The county in which the property and other assets are located; and

(d) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(5) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, on behalf of the decedent alleged by the department's notice is correct; and

(b) Whether the decedent had legal title to the identified property.

(6) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(7) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property of the time and place of the administrative hearing.

(8) An administrative hearing under this subsection is governed by chapters 34.05 RCW and 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.

(9) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the client's property and other assets if upheld by the final agency decision.

(10) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (3) of this section.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2820, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2830 Request for notice of transfer or encumbrance. (1) When a client receives medical assistance subject to recovery under this chapter and the client is the holder of record title to real property or the purchaser under a land sale contract, the department files a request for notice of transfer or encumbrance [DSHS form 18-664 Notice of Possible Debt] with the county auditor for recording in the deed and mortgage records.

(2) The request for notice of transfer or encumbrance [DSHS 18-664] complies with the requirements for recording in RCW 36.18.010, and, at a minimum, contains the:

(a) Client's name and case identifier;

(b) Legal description of the real property, including parcel number; and

(c) Mailing address for the department to receive the notice of transfer or encumbrance.

(3) The request for notice of transfer or encumbrance [18-664] described in subsection (1) of this section does not affect title to real property and is not a lien on, encumbrance of, or other interest in the real property.

(4) When filing a request for notice of transfer or encumbrance [DSHS 18-664] with the county auditor, the department gives the opportunity to request an administrative hearing as follows:

(a) Any person known to have title to the property is served with a copy of the notice. The notice states:

(i) The department's intent to recover from the client's estate the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the client;

(ii) The county in which the property is located; and

(iii) The right of the person known to have title in the property to contest the department's decision to file the notice by applying for an administrative hearing with the office of financial recovery (OFR).

(b) An administrative hearing only determines:

(i) Whether the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the client alleged by the department's notice is correct; and

(ii) Whether the client has legal title to the identified property.

(5) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the department's notice;

(c) Be signed by the requester and state the requester's address and telephone number; and

(d) Be served on OFR as described in WAC 388-527-2870, within twenty-eight calendar days of the date the individual received the department's notice.

(6) Upon receiving a request for an administrative hearing, the department notifies the persons known to have title to the property of the time and place of the administrative hearing.

(7) An administrative hearing under this section is governed by chapters 388-05 RCW and 388-02 WAC, and this section. If a provision of this section conflicts with a provision in chapter 388-02 WAC, the provision of this section governs.

(8) A title insurance company or agent that discovers the presence of a request for notice of transfer or encumbrance [DSHS 18-664] when performing a title search on real property must disclose the presence of the request for notice or transfer or encumbrance of real property in any report preliminary to, or commitment to offer, a certificate of title insurance for the real property.

(9) If the department has filed a request for notice of transfer or encumbrance [DSHS 18-664], any individual who transfers or encumbers real property must provide the department with a notice of transfer or encumbrance [DSHS 18-663] as described in WAC 388-527-2850.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2830, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2840 Termination of request for notice of transfer or encumbrance. (1) The department files a termination of prior notice [DSHS 18-662] of transfer or encumbrance, with the county auditor for recording when, in the judgment of the department, it is no longer necessary or appropriate for the department to monitor transfers or encumbrances related to the real property.

(2) The termination of prior notice [DSHS 18-662] request for notice of transfer or encumbrance complies with the requirements for recording in RCW 36.18.010, and, at a minimum, contains the:

(a) Client's name and case identifier;

(b) Legal description of the real property, including parcel number; and

(c) Mailing address for the department to receive the notice of transfer or encumbrance.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2840, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2850 Notice of transfer or encumbrance. (1) If the department has filed a request for notice of transfer or encumbrance [DSHS 18-664 Notice of Possible Debt], any individual who transfers or encumbers real property must provide the department with a notice of transfer or encumbrance [DSHS 18-663] or a substantially similar notice as required by chapter 43.20B RCW.

(2) The department's notice of transfer or encumbrance [DSHS 18-663] is available on-line at http://www1.dshs.wa.

gov/msa/forms/eforms.html or by writing to Forms and Records Management Services, PO Box 45805, Olympia, WA 98504-5805.

(3) The notice of transfer or encumbrance [DSHS 18-663] must comply with the requirements for recording in RCW 36.18.010, and, at a minimum, contain the:

(a) Client's name and case identifier as listed on the department's request for notice of transfer or encumbrance;

(b) Recording date and recording reference as listed on the department's request for notice of transfer or encumbrance;

(c) Legal description of the real property as listed on the department's request for notice of transfer or encumbrance; and

(d) Type of instrument; and

(e) Recording date and recording reference.

(4) The notice of transfer or encumbrance [DSHS 18-663] or a similar notice and copy of the transfer or encumbrance related to the real property must be sent to the department as specified in WAC 388-527-2870.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2850, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2860 Interest assessed on past due debt. (1) The recovery debt becomes past due and accrues interest at a rate of one percent per month on recoverable estate assets beginning nine months after the earlier of:

(a) The filing of the department's creditor's claim in the probate of the deceased client's estate; or

(b) The recording of the department's lien against the property of the deceased client in the county where the property is located.

(2) The department may waive interest if:

(a) Insufficient cash, accounts, or stock exist to satisfy the department's claim and no sales of estate property has occurred despite its continuous listing or marketing for sale in a commercially reasonable manner for a reasonable fair market value; or

(b) Suit filed in the probate of the deceased client's estate resulted in the filing of a lis pendens or order prohibiting the personal representative from selling the estate property. However, this section does not apply to such suite contesting the department's assessment of interest or claim for reimbursement of medical assistance or state-only funded long-term care services debt.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2860, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2870 Serving notices on the office of financial recovery (OFR). Serving legal notice on the office of financial recovery (OFR) requires the notice to be served either:

(1) In person at the Blake Office Park, 4450 10th Ave SE, Lacey, Washington; or

(2) By certified mail, return receipt requested, to Office of Financial Recovery, PO Box 9501, Olympia, WA 98507-9501.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2870, filed 8/14/06, effective 9/14/06.]

Chapter 388-530 WAC
PRESCRIPTION DRUGS (OUTPATIENT)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 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.

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. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1450, 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.

388-530-1500 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 reimburse providers for outpatient drugs, vitamins, minerals, 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, vitamins, minerals, devices, and pharmaceutical supplies that are:

(a) Covered. Refer to WAC 388-530-2000 for covered drugs, vitamins, minerals, devices, and drug-related supplies and to WAC 388-530-2100 for noncovered drugs and drug-related supplies;

(b) Prescribed by a provider with prescriptive authority (see exceptions for family planning and emergency contraception for women eighteen years of age and older in WAC 388-530-2000 (1)(b), and over-the-counter (OTC) drugs to promote smoking cessation in WAC 388-530-2000 (1)(a)(v);

(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) Coverage determinations for the department are made by the department's pharmacists or medical consultants in accordance with applicable federal law. The department's determination may include consultation with the drug use review (DUR) board.

(4) The department may not reimburse for prescriptions written by healthcare practitioners whose application for a core provider agreement (CPA) has been denied, or whose CPA has been terminated.

(5) The department may not reimburse 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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-1000, filed 10/16/08, effective 11/16/08. 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 AAC 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, medically 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" - 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 efficacy 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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-1050, filed 10/16/08, effective 11/16/08. 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.]

WAC 388-530-1075 Requirements—Use of tamper-resistant prescription pads. (1) The department requires providers to use tamper-resistant prescription pads or paper for written outpatient prescriptions, including over-the-counter drugs, for medical assistance clients.

(2) This requirement applies to all outpatient prescription drugs including:

(a) Prescriptions when medicaid is primary or secondary payer (including medicare Part D prescriptions).

(b) Signed hardcopy prescriptions given to a client, whether handwritten or computer-generated.

(3) This requirement does not apply to:

(a) Prescriptions paid for by Washington's healthy options (HO) program or other department contracted managed care organizations.

(b) Prescription drugs that are part of the per diem or bundled rate and not reimbursed separately in designated institutional or clinical settings, such as a nursing facility, ICF/MR, dental office, hospice, or radiology. For example, a morphine prescription used to control a hospice client's cancer pain is covered under the hospice per diem rate and therefore the tamper-resistant prescription requirement is not required.

(c) Telephone, fax or electronic prescriptions.

(d) Refill prescriptions, if the original written prescriptions were presented at a pharmacy before April 1, 2008.

(e) Prescriber or clinic drug samples given directly to the client.

(f) An institutional setting, as defined in WAC 388-500-0005, where the prescriber writes the order into the medical records and the orders go directly to the pharmacy.

(4) Effective April 1, 2008, the tamper-resistant prescription pads and paper must meet at least one of the following industry recognized characteristics:

(a) One or more features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or

(c) One or more features designed to prevent the use of counterfeit prescription forms.

(5) Effective October 1, 2008, the tamper-resistant prescription pads and paper must contain all of the three characteristics in subsection (4) of this section.

(6) If the written prescription is not on tamper-resistant paper, the pharmacy may provide the prescription on an emergency basis. The pharmacy must verify the prescription with the prescriber by telephone, fax, or electronic communication, or by physical receipt of a tamper-resistant written prescription within seventy-two hours of filling the prescription.

(7) Federal controlled substance laws on controlled substances apply when prescribing or dispensing schedule II drugs.

(8) Record retention requirements (WAC 388-502-0020) remain in effect. Additional documentation is required as follows:

(a) Documentation by the pharmacy of verbal confirmation of a noncompliant written prescription.

(b) Documentation by the pharmacy of verbal confirmation about the authenticity of the tamper-resistant prescription.

(9) To submit a claim for a medicaid client retroactively certified for medicaid, the following applies:

(a) The prescription must meet the tamper-resistant compliance requirement.

(b) Refills that occur after the date on which the client is determined to be eligible require a new, tamper-resistant prescription in compliance with this WAC.

(c) If the original order is not compliant with subsection (4) of this section, the pharmacy must obtain a verbal, faxed, or email confirmation of the prescription from the prescriber.

(d) The pharmacy must reimburse the client in accordance with WAC 388-502-0160.

(10) The pharmacy accepting a prescription transfer from another pharmacy must confirm the authenticity of the prescription by telephone or facsimile from the transferring pharmacy.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.500 and Section 1903(i) of the Social Security Act (42 U.S.C. Section 1936b (i)(23)); Section 7002(b), U.S. Troop Readiness, Veterans' Care, Katrina Recovery,

and Iraq Accountability Appropriations Act, 2007 (Pub.L. 110-28). 08-07-048, § 388-530-1075, filed 3/14/08, effective 4/14/08.]

COVERAGE

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;

(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; and

(v) Prescribed by a provider with prescriptive authority (see exceptions for family planning and emergency contraception for women eighteen years of age and older in WAC 388-530-2000 (1)(b), and over-the-counter (OTC) drugs to promote smoking cessation in WAC 388-530-2000 (1)(g).

(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 prescribed for clients under the age of twenty-one.

(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.

(f) Over-the-counter (OTC) drugs, without a prescription, to promote smoking cessation only for clients who are eighteen years of age or older and participating in a department-approved smoking cessation program. Limitation extensions as described in WAC 388-501-0169 are prohibited for the age and counseling requirements in this section.

(g) Prescription drugs to promote smoking cessation only for clients who are eighteen years of age or older and participating in a department-approved smoking cessation program. Limitation extensions as described in WAC 388-501-0169 are prohibited for the age and counseling requirements in this section.

(2) 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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-2000, filed 10/16/08, effective 11/16/08. 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 a 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; or

(iv) For cosmetic purposes or hair growth.

(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.

(i) Over-the-counter or prescription drugs to promote smoking cessation unless the client is eighteen years old or older and participating in a department-approved cessation program.

(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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-2100, filed 10/16/08, effective 11/16/08. 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.]

AUTHORIZATION

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; and

(f) 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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-3000, filed 10/16/08, effective 11/16/08. 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 circum-

stances 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 therapeutically equivalent alternative.

(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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-3200, filed 10/16/08, effective 11/16/08. 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.]

QUALITY OF CARE

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 that have been studied by the evidence-based practice center and have reviewed by the P&T committee may be included in the Washington PDL.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. 08-21-107, § 388-530-4100, filed 10/16/08, effective 11/16/08. 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) When the pharmacy and therapeutics (P&T) committee determines that TIP does not apply to the therapeutic class on the PDL; or

(b) 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, 74.09.700, 2008 c 245. 08-21-107, § 388-530-4150, filed 10/16/08, effective 11/16/08. 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.]

BILLING

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.]

MAIL-ORDER SERVICES

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 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.]

REIMBURSEMENT

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 nonmedicaid 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 nonmedicaid 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 nonmedicaid) 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 documentation 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.]

REIMBURSEMENT METHODOLOGY

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 388-531 WAC
PHYSICIAN-RELATED SERVICES

WAC

WAC 388-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Acquisition cost" means the cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" means care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 388-550-2501).

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" means the medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

"Advanced registered nurse practitioner (ARNP)" means a registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and disability services administration (ADSA)" means the administration that administers directly or contracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-71-0202.

"Allowed charges" means the maximum amount reimbursed for any procedure that is allowed by MAA.

"Anesthesia technical advisory group (ATAG)" means an advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" means any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" means a number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" means services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" means supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)" means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Call" means a face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" means a reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Centers for Medicare and Medicaid Services (CMS)" means the agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for medicare and medicaid programs.

"Certified registered nurse anesthetist (CRNA)" means an advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 388-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" means regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" means dollar amounts MAA uses to calculate the maximum allowable fee for physician-related services.

"Covered service" means a service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" means physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" means 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).

"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.

"Emergency medical condition(s)" means a medical condition(s) that manifests itself by acute symptoms of sufficient severity so 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.

"Emergency services" means medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" means the department's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" means procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" means the process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 388-531-0550. 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 method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's healthy options program or children's health insurance program (CHIP) programs.

"Flat fee" means the maximum allowable fee established by MAA for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" as defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 388-531-1700.

"HCPCS Level II" means a coding system established by CMS (formerly known as the Health Care Financing Administration) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" means the name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" means a group of health care providers involved in the care of a client.

"Hospice" means a medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD-9-CM," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"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 client's diagnosis; and

(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" means an admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumerical designations (coding).

"Investigational" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" means mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension" means a process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 388-500-0005.

"Medicare physician fee schedule data base (MPFSDB)" means the official HCFA publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" means the official HCFA publication of the medicare fees for physician services.

"Medicare clinical diagnostic laboratory fee schedule" means the fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court.

"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 physician 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.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Peer-reviewed medical literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" means a written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" means physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "CPT, current procedural terminology."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" means the diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" means a symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not routinely covered.

"Preventive" means medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

"Professional component" means the part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" means the probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" means face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 388-500-0005.

"Radioallergosorbent test" or **"RAST"** means a blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RVU," see relative value unit.

"Reimbursement" means payment to a provider or other MAA-approved entity who bills according to the provisions in WAC 388-502-0100.

"Reimbursement steering committee (RSC)" means an interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"Relative value guide (RVG)" means a system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" means a unit which is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RBRVS RVU" means a measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"RSC RVU" means a unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"Stat laboratory charges" means charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" means a tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by HCFA to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" means an advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"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 the procedure and service reimbursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-059, § 388-531-0050, 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. 03-19-081, § 388-531-0050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090. 03-06-049, § 388-531-0050, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0100 Scope of coverage for physician-related services—General and administrative. (1) The department covers healthcare services, equipment, and supplies listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060 and 388-501-0065; and

(b) Medically necessary as defined in WAC 388-500-0005.

(2) The department evaluates a request for a service that is in a covered category under the provisions of WAC 388-501-0165.

(3) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(4) The department covers the following physician-related services, subject to the conditions in subsections (1), (2), and (3) of this section:

(a) Allergen immunotherapy services;

(b) Anesthesia services;

(c) Dialysis and end stage renal disease services (refer to chapter 388-540 WAC);

(d) Emergency physician services;

(e) ENT (ear, nose, and throat) related services;

(f) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 388-534-0100);

(g) Family planning services (refer to chapter 388-532 WAC);

(h) Hospital inpatient services (refer to chapter 388-550 WAC);

(i) Maternity care, delivery, and newborn care services (refer to chapter 388-533 WAC);

(j) Office visits;

(k) Vision-related services, refer to chapter 388-544 WAC;

(l) Osteopathic treatment services;

(m) Pathology and laboratory services;

(n) Physiatry and other rehabilitation services (refer to chapter 388-550 WAC);

(o) Podiatry services;

(p) Primary care services;

(q) Psychiatric services, provided by a psychiatrist;

(r) Psychotherapy services for children as provided in WAC 388-531-1400;

(s) Pulmonary and respiratory services;

(t) Radiology services;

(u) Surgical services;

(v) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects

from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment; and

(w) Other outpatient physician services.

(5) The department covers physical examinations for medical assistance clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 388-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(6) By providing covered services to a client eligible for a medical assistance program, a provider who has signed an agreement with the department accepts the department's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and department issuances.

[Statutory Authority: RCW 74.09.521. 08-12-030, § 388-531-0100, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-531-0100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0150 Noncovered physician-related services—General and administrative. (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, MAA does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when MAA determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is not limited to:

(i) Treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of flat feet;

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services.

(o) Nonmedical equipment; and

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas.

(2) MAA covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0150, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0200 Physician-related services requiring prior authorization. (1) MAA requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE).** See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in MAA's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to MAA showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in MAA billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for geynecomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) MAA evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R);**

(c) Cochlear implants, which also:

(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim;

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of MAA's published limits;

(f) Panniculectomy;

(g) Bariatric surgery (see WAC 388-531-1600); and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(5) MAA may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(6) Children six year of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0200, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0250 Who can provide and bill for physician-related services. (1) The following enrolled providers are eligible to provide and bill for physician-related healthcare services which they provide to eligible clients:

(a) Advanced registered nurse practitioners (ARNP);

(b) Federally qualified health centers (FQHCs);

(c) Health departments;

(d) Hospitals currently licensed by the department of health;

(e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;

(f) Licensed marriage and family therapists, only as provided in WAC 388-531-1400;

(g) Licensed mental health counselors, only as provided in WAC 388-531-1400;

(h) Licensed radiology facilities;

(i) Licensed social workers, only as provided in WAC 388-531-1400 and 388-531-1600;

(j) Medicare-certified ambulatory surgery centers;

(k) Medicare-certified rural health clinics;

(l) Providers who have a signed agreement with the department to provide screening services to eligible persons in the EPSDT program;

(m) Registered nurse first assistants (RNFA); and

(n) Persons currently licensed by the state of Washington department of health to practice any of the following:

(i) Dentistry (refer to chapter 388-535 WAC);

(ii) Medicine and osteopathy;

(iii) Nursing;

(iv) Optometry; or

(v) Podiatry.

(2) The department does not pay for services performed by any of the following practitioners:

(a) Acupuncturists;

(b) Christian Science practitioners or theological healers;

(c) Counselors, except as provided in WAC 388-531-1400;

(d) Herbalists;

(e) Homeopaths;

(f) Massage therapists as licensed by the Washington state department of health;

(g) Naturopaths;

(h) Sanipractors;

(i) Social workers, except those who have a master's degree in social work (MSW), and:

(i) Are employed by an FQHC;

(ii) Who have prior authorization to evaluate a client for bariatric surgery; or

(iii) As provided in WAC 388-531-1400.

(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or

(k) Any other licensed practitioners providing services which the practitioner is not:

(i) Licensed to provide; and

(ii) Trained to provide.

(3) The department pays practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified medicare beneficiaries (QMB); or

(c) A waiver program.

[Statutory Authority: RCW 74.09.521. 08-12-030, § 388-531-0250, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0250, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0300 Anesthesia providers and covered physician-related services. MAA bases coverage of anesthesia services on medicare policies and the following rules:

(1) MAA reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) **Certified registered nurse anesthetists (CRNAs);**

(c) Oral surgeons with a special agreement with MAA to provide anesthesia services; and

(d) Other providers who have a special agreement with MAA to provide anesthesia services.

(2) MAA covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) MAA covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 388-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a pre-anesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) MAA does not allow the anaesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) MAA requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, MAA reimburses the base anesthesia units (BAU) for the major procedure only.

(b) MAA does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, MAA reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, MAA limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) MAA pays CRNAs or anesthesiologists for pain management services.

(b) MAA allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) MAA does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) MAA reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) MAA calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: (BAU x fifteen) + time) x (conversion factor divided by fifteen) = reimbursement.

(3) MAA obtains BAU values from the relative value guide **(RVG)**, and updates them annually. MAA and/or the anesthesia technical advisory group **(ATAG)** members establish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) MAA determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

(5) MAA calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) MAA changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as MAA's

annual update, MAA applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, MAA uses the BAU of the major procedure to determine anesthesia **allowed charges.** MAA reimburses add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC 388-501-0100, for services that are not covered under the client's medical care program. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0450 Critical care—Physician-related services. (1) MAA reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) MAA reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing MAA.

(3) MAA limits payment for critical care services to a maximum of three hours per day, per client.

(4) MAA does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0500 Emergency physician-related services. (1) MAA reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) MAA reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on **call** to cover the hospital emergency department.

(3) MAA pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

(4) MAA does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0550 Experimental and investigational services. (1) When MAA makes a determination as to whether a proposed service is experimental or investigational, MAA follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. MAA also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and preclinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3) MAA applies consistently across clients with the same medical condition and health status, the criteria to

determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) MAA does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;

(b) Designated by MAA's medical director to issue such approvals; and

(c) Available to consult with the client's treating physician by telephone.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0600 HIV/AIDS Counseling and testing as physician-related services. MAA covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0650 Hospital physician-related services not requiring authorization when provided in MAA-approved centers of excellence or hospitals authorized to provide the specific services. MAA covers the following services without prior authorization when provided in MAA-approved centers of excellence. MAA issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;

(3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. MAA allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0650, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0700 Inpatient chronic pain management physician-related services. (l) MAA covers inpatient chronic pain management services only when the services are obtained through an MAA-approved chronic pain facility.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had chronic pain for at least three months, that 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) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

(3) For chronic pain management, MAA limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.

(4) MAA reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0750 Inpatient hospital physician-related services. (1) MAA separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) MAA reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement,** MAA does not reimburse separately.

(3) MAA reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0800 Laboratory and pathology physician-related services. (1) MAA reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) MAA includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) MAA reimburses only one blood drawing fee per client, per day. MAA allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) MAA reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) MAA reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, MAA reimburses the test at the individual procedure code

rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) MAA allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) MAA reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) MAA reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) MAA does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) MAA does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) MAA may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill MAA directly. MAA does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0850 Laboratory and pathology physician-related services reimbursement. (1) MAA pays for clinical diagnostic laboratory procedures based on the **medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. MAA obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) MAA updates budget-neutral fees each July by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Determining in total the ratio of current MAA fees to existing medicare fees. Then,

(c) Determining new MAA fees by adjusting the new medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new MAA fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) MAA calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing **RSC** fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or **"flat fees"** for procedure codes that have no applicable MCDLF or RSC fees. MAA updates flat fee reimbursement only when authorized by the legislature.

(d) MAA reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) MAA increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating budget-neutral fees.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0900 Neonatal intensive care unit (NICU) physician-related services. (1) MAA pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) MAA reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to **prolonged services** and newborn resuscitation when the provider is present at the delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0950 Office and other outpatient physician-related services. (l) MAA reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and.

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (l) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, MAA reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) MAA may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) MAA does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) MAA does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; MAA does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, MAA reimburses a minimum E&M service.

(8) MAA reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. MAA reimburses a separate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) MAA reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) MAA does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. MAA does pay separately for the administration of these injections when they are provided on the same day as an E&M service. MAA does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. MAA reimburses separately for the drug(s).

(b) MAA does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, MAA pays an administrative fee. MAA reimburses separately for the drug.

(c) MAA reimburses injectable drugs at **acquisition cost.** The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by MAA. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing MAA for the following drugs:

(i) Classified drugs where the billed charge to MAA is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to MAA is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) MAA reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, MAA reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) MAA covers the antigen, the antigen preparation, and an administration fee.

(e) MAA reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) MAA reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) MAA reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The national drug code (NCD).

(12) Notwithstanding the provisions of this section, MAA reserves the option of determining drug pricing for any particular drug based on the best evidence available to MAA, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) MAA may request an invoice as necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1000 Ophthalmic physician-related services. Refer to chapter 388-544 WAC for ophthalmic and vision-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1000, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1050 Osteopathic manipulative treatment. (1) MAA reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) MAA reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) MAA allows an osteopathic physician to bill MAA for an E&M service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition signifi-

cantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) MAA limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) MAA does not reimburse for physical therapy services performed by osteopathic physicians.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1100 Out-of-state physician services. (1) MAA covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.

(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. MAA considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1150 Physician care plan oversight services. (1) MAA covers **physician care plan** oversight services only when:

(a) A physician provides the service; and

(b) The client is served by a home health agency, a nursing facility, or a **hospice**.

(2) MAA reimburses for physician care plan oversight services when both of the following apply:

(a) The facility/agency has established a plan of care; and

(b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.

(3) MAA reimburses only one physician per client, per month, for physician care plan oversight services.

(4) MAA reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1200 Physician office medical supplies. (1) Refer to RBRVS billing instructions for a list of:

(a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and

(b) Supplies that can be billed separately and that MAA considers nonroutine to office or outpatient procedures.

(2) MAA reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to MAA upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) MAA reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1250 Physician standby services. (1) MAA reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) MAA does not reimburse physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than thirty minutes; or

(c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. MAA reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. MAA rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1300 Podiatric physician-related services. (1) MAA covers podiatric services as listed in this section when provided by any of the following:

(a) A medical doctor;

(b) A doctor of osteopathy; or

(c) A podiatric physician.

(2) MAA reimburses for the following:

(a) Nonroutine foot care when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;

(b) One treatment in a sixty-day period for debridement of nails. MAA covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting. MAA includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. MAA does not reimburse separately for the anesthesia, but includes it in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices:

(i) MAA's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the

foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) MAA includes an E&M fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) MAA does not reimburse podiatrists for any of the following radiology services:

(a) X rays for soft tissue diagnosis;

(b) Bilateral X rays for a unilateral condition;

(c) X rays in excess of two views;

(d) X rays that are ordered before the client is examined; or

(e) X rays for any part of the body other than the foot or ankle.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1350 Prolonged physician-related service. (1) MAA reimburses prolonged services based on established medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician and the client; and

(b) Be provided with other services.

(2) MAA allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1400 Psychiatric physician-related services and other professional mental health services. (1) The mental health services covered in the medical benefits described in this section are separate from the mental health services covered by the mental health managed care system administered under the authority of the mental health division pursuant to chapter 388-865 WAC. The department covers outpatient mental health services with the following limitations:

(a) For clients eighteen years of age and younger:

(i) The department pays for only one hour per day, per client, up to a total of twenty hours per calendar year, including the psychiatric diagnostic evaluation and family therapy visits that are medically necessary to the client's treatment;

(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric advanced registered nurse practitioners (ARNP) in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and

(iii) The mental health services must be provided in an outpatient setting by a psychiatrist, psychologist, psychiatric ARNP, social worker, marriage and family therapist, or mental health counselor who must:

(A) Be licensed, in good standing and without restriction, by the department of health under their appropriate licensure; and

(B) Have a minimum of two years experience in the diagnosis and treatment of clients eighteen years of age and younger and their families, including a minimum one year under the supervision of a mental health professional trained in child and family mental health. A licensed psychiatrist may provide these services and bill the department without meeting this requirement.

(b) For clients nineteen years of age and older:

(i) The department pays for only one hour per day, per client, up to a total of twelve hours per calendar year, including family or group therapy visits;

(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric ARNPs in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and

(iii) The mental health services must be provided by a psychiatrist in an outpatient setting.

(2) The department covers inpatient mental health services with the following limitations:

(a) Must be provided by a psychiatrist;

(b) Only the total time spent on direct psychiatric client care during each visit; and

(c) One hospital call per day for direct psychiatric client care, including making rounds. Making rounds is considered direct client care and includes any one of the following:

(i) Individual psychotherapy up to one hour;

(ii) Family/group therapy; or

(iii) Electroconvulsive therapy.

(3) With the exception of medication management, the department covers other mental health services described in this section with the limitation of one per client, per day regardless of location or provider type.

(4) The department pays psychiatrists when the client receives a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) The department covers psychiatric diagnostic interview evaluations at the limit of one per provider, per calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the department.

(6) The department does not cover psychiatric sleep therapy.

(7) The department covers electroconvulsive therapy and narcosynthesis only when performed by a psychiatrist.

(8) The department pays psychiatric ARNPs only for mental health medication management and diagnostic interview evaluations provided to clients nineteen years of age and older.

(9) The department covers interactive, face-to-face visits at the limit of one per client, per day, in an outpatient setting. Interactive, face-to-face visits may be billed only for clients age twenty and younger.

(10) The client or licensed healthcare provider may request a limitation extension only when the client exceeds

the total hour limit described in subsection (1) of this section, and for no other limitation of service in this section. The department will evaluate these requests in accordance with WAC 388-501-0169.

(11) DSHS providers must comply with chapter 388-865 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the mental health division or the appropriate regional support network (RSN).

(12) Accepting payment under more than one contract or agreement with the department for the same service for the same client constitutes duplication of payment. If a client is provided services under multiple contracts or agreements, each provider must maintain documentation identifying the type of service provided and the contract or agreement under which it is provided to ensure it is not a duplication of service.

[Statutory Authority: RCW 74.09.521. 08-12-030, § 388-531-1400, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1450 Radiology physician-related services. (1) MAA reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) MAA does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) MAA reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by MAA, and reimbursement is at acquisition cost.

(4) MAA reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) MAA reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) MAA reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) MAA reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contract media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1500 Sleep studies. (1) MAA covers sleep studies only when all of the following apply:

(a) The study is done to establish a diagnosis of narcolepsy or of sleep apnea;

(b) The study is done only at an MAA-approved sleep study center that meets the standards and conditions in subsections (2), (3), and (4) of this section; and

(c) An ENT consultation has been done for a client under ten years of age.

(2) In order to become an MAA-approved sleep study center, a sleep lab must send MAA verification of both of the following:

(a) Sleep lab accreditation by the American Academy of Sleep Medicine; and

(b) Physician's Board Certification by the American Board of Sleep Medicine.

(3) Registered polysomnograph technicians (PSGT) must meet the accreditation standards of the American Academy of Sleep Medicine.

(4) When a sleep lab changes directors, MAA requires the provider to submit accreditation for the new director. If an accredited director moves to a facility that MAA has not approved, the provider must submit certification for the facility.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. A hysterectomy is a surgical procedure or operation for the purpose of removing the uterus. Hysterectomy results in sterilization, but MAA does not cover hysterectomy performed solely for that purpose. Both hysterectomy and sterilization procedures require the use of specific consent forms.

STERILIZATION

(2) MAA covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time consent is signed;

(b) The client is a mentally competent individual;

(c) The client has voluntarily given **informed consent** in accordance with all the requirements defined in this subsection; and

(d) At least thirty days, but not more than one hundred eighty days, have passed between the date the client gave informed consent and the date of the sterilization.

(3) MAA does not require the thirty-day waiting period, but does require at least a seventy-two hour waiting period, for sterilization in the following circumstances:

(a) At the time of premature delivery, the client gave consent at least thirty days before the expected date of delivery. The expected date of delivery must be documented on the consent form;

(b) For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

(4) MAA waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(5) MAA does not accept informed consent obtained when the client is in any of the following conditions:

(a) In labor or childbirth;

(b) Seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances that affect the client's state of awareness.

(6) MAA has certain consent requirements that the provider must meet before MAA reimburses sterilization of a **mentally incompetent** or institutionalized client. MAA requires both of the following:

(a) A court order; and

(b) A sterilization consent form signed by the legal guardian, sent to MAA at least thirty days prior to the procedure.

(7) MAA reimburses epidural anesthesia in excess of the six-hour limit for sterilization procedures that are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

(a) Adding the time for the sterilization procedure to the time for the delivery; and

(b) Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.

(c) The provider cannot bill separately for the BAUs for the sterilization procedure.

(8) The physician identified in the "consent to sterilization" section of the DSHS-approved sterilization consent form must be the same physician who completes the "physician's statement" section and performs the sterilization procedure. If a different physician performs the sterilization procedure, the client must sign and date a new consent form at the time of the procedure that indicates the name of the physician performing the operation under the "consent for sterilization" section. This modified consent must be attached to the original consent form when the provider bills MAA.

(9) MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

HYSTERECTOMY

(10) Hysterectomies performed for medical reasons may require expedited prior authorization as explained in WAC 388-531-0200(2).

(11) MAA reimburses hysterectomy without prior authorization in either of the following circumstances:

(a) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(b) The client is forty-six years of age or older.

(12) MAA reimburses all attending providers for the hysterectomy procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. If a prior authorization number is necessary for the procedure, it must be on the claim. MAA reimburses after the procedure is completed.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1600 Bariatric surgery. (1) The department covers medically necessary bariatric surgery for eligible clients.

(2) Bariatric surgery must be performed in a hospital with a bariatric surgery program, and the hospital must be:

(a) Located in the state of Washington or approved border cities (see WAC 388-501-0175); and

(b) Meet the requirements of WAC 388-550-2301.

(3) If bariatric surgery is requested or prescribed under the EPSDT program, the department evaluates it as a covered service under EPSDT's standard of coverage that requires the service to be:

(a) Medically necessary;

(b) Safe and effective; and

(c) Not experimental.

(4) The department authorizes payment for bariatric surgery and bariatric surgery-related services in three stages:

(a) Stage one—Initial assessment of client;

(b) Stage two—Evaluations for bariatric surgery and successful completion of a weight loss regimen; and

(c) Stage three—Bariatric surgery.

Stage one—Initial assessment

(5) Any department-enrolled provider who is licensed to practice medicine in the state of Washington may examine a client requesting bariatric surgery to ascertain if the client meets the criteria listed in subsection (6) of this section.

(6) The client meets the preliminary conditions of stage one when:

(a) The client is between twenty-one and fifty-nine years of age;

(b) The client has a body mass index (BMI) of thirty-five or greater;

(c) The client is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery);

(d) The client is diagnosed with one of the following:

(i) Diabetes mellitus;

(ii) Degenerative joint disease of a major weight bearing joint(s) (the client must be a candidate for joint replacement surgery if weight loss is achieved); or

(iii) Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality; and

(e) The client has an absence of other medical conditions such as multiple sclerosis (MS) that would increase the client's risk of surgical mortality or morbidity from bariatric surgery.

(7) If a client meets the criteria in subsection (6) of this section, the provider must request prior authorization from the department before referring the client to stage two of the bariatric surgery authorization process. The provider must attach a medical report to the request for prior authorization with supporting documentation that the client meets the stage one criteria in subsections (5) and (6) of this section.

(8) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the provisions of WAC 388-501-0165 and 388-501-0169.

Stage two—Evaluations for bariatric surgery and successful completion of a weight loss regimen

(9) After receiving prior authorization from the department to begin stage two of the bariatric surgery authorization process, the client must:

(a) Undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. Upon completion, the results of the evaluation must be forwarded to the department. The comprehensive psychosocial evaluation must include:

(i) An assessment of the client's mental status or illness to:

(A) Evaluate the client for the presence of substance abuse problems or psychiatric illness which would preclude the client from participating in presurgical dietary requirements or postsurgical lifestyle changes; and

(B) If applicable, document that the client has been successfully treated for psychiatric illness and has been stabilized for at least six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.

(ii) An assessment and certification of the client's ability to comply with the postoperative requirements such as lifelong required dietary changes and regular follow-up.

(b) Undergo an internal medicine evaluation performed by an internist to assess the client's preoperative condition and mortality risk. Upon completion, the internist must forward the results of the evaluation to the department.

(c) Undergo a surgical evaluation by the surgeon who will perform the bariatric surgery (see subsection (13) of this section for surgeon requirements). Upon completion, the surgeon must forward the results of the surgical evaluation to the department and to the licensed medical provider who is supervising the client's weight loss regimen (refer to WAC 388-531-1600 (9)(d)(ii)).

(d) Under the supervision of a licensed medical provider, the client must participate in a weight loss regimen prior to surgery. The client must, within one hundred and eighty days from the date of the department's stage one authorization, lose at least five percent of his or her initial body weight. If the client does not meet this weight loss requirement within one hundred and eighty days from the date of the department's initial authorization, the department will cancel the authorization. The client or the client's provider must reapply for prior authorization from the department to restart stage two. For the purpose of this section, "initial body weight" means the client's weight at the first evaluation appointment.

(i) The purpose of the weight loss regimen is to help the client achieve the required five percent loss of initial body weight prior to surgery and to demonstrate the client's ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery.

(ii) The weight loss regimen must:

(A) Be supervised by a licensed medical provider who has a core provider agreement with the department;

(B) Include monthly visits to the medical provider;

(C) Include counseling twice a month by a registered dietician referred to by the treating provider or surgeon; and

(D) Be at least six months in duration.

(iii) Documentation of the following requirements must be retained in the client's medical file. Copies of the documentation must be forwarded to the department upon completion of stage two. The department will evaluate the documentation and authorize the client for bariatric surgery if the stage two requirements were successfully completed.

(A) The provider must document the client's compliance in keeping scheduled appointments and the client's progress toward weight loss by serial weight recordings. Clients must lose at least five percent loss of initial body weight and must maintain the five percent weight loss until surgery;

(B) For diabetic clients, the provider must document the efforts in diabetic control or stabilization;

(C) The registered dietician must document the client's compliance (or noncompliance) in keeping scheduled appointments, and the client's weight loss progress;

(D) The client must keep a journal of active participation in the medically structured weight loss regimen including the activities under (d)(iii)(A), (d)(iii)(B) if appropriate, and (d)(iii)(C) of this subsection.

(10) If the client fails to complete all of the requirements of subsection (9) of this section, the department will not authorize stage three—Bariatric surgery.

(11) If the client is unable to meet all of the stage two criteria, the client or the client's provider must reapply for prior authorization from the department to reenter stage two.

Stage three—Bariatric surgery

(12) The department may withdraw authorization of payment for bariatric surgery at any time up to the actual surgery if the department determines that the client is not complying with the requirements of this section.

(13) A surgeon who performs bariatric surgery for medical assistance clients must:

(a) Have a signed core provider agreement with the department;

(b) Have a valid medical license in the state of Washington; and

(c) Be affiliated with a bariatric surgery program that meets the requirements of WAC 388-550-2301.

(14) For hospital requirements for stage three—Bariatric surgery, see WAC 388-530-2301.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-531-1600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-1600, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-1600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1650 Substance abuse detoxification physician-related services. (1) MAA covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in an MAA-enrolled hospital-based detoxification center.

(2) MAA covers treatment in programs certified under chapter 388-805 WAC or its successor.

(3) MAA covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-081, § 388-531-1650, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1700 Surgical physician-related services. (1) MAA's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) MAA's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) MAA's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, MAA does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) MAA's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of MAA's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of MAA's allowed fee for each procedure.

(6) MAA allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) MAA's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, MAA pays the full amount of the procedure with the highest maximum allowable fee.

(d) MAA pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) MAA does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) MAA restricts reimbursement for surgery assists to selected procedures as follows:

(a) MAA applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) MAA bases payment splits between preoperative, intraoperative, and postoperative services on medicare determinations for given surgical procedures or range of procedures. MAA pays any procedure that does not have an established medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1750 Transplant coverage for physician-related services. MAA covers transplants when performed in an MAA-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC 388-550-2000 for information about medical criteria to receive transplants.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(l) MAA bases the payment methodology for most physician-related services on medicare's RBRVS. MAA obtains information used to update MAA's RBRVS from the **MPFSPS.**

(2) MAA updates and revises the following RBRVS areas each January prior to MAA's annual update.

(3) MAA determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a **base period.** Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels.

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) MAA calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, MAA establishes maximum allowable fees, also known as "flat" fees.

(i) MAA does not use the conversion factor for these codes.

(ii) MAA updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, MAA pays the provider a flat fee only for administering the immunization.

(B) A **cast material maximum allowable fee** is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, MAA reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) MAA reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The **technical advisory group** reviews RBRVS changes.

(6) MAA also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, MAA applies the increase after calculating budget-neutral fees. MAA pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) MAA does not allow separate reimbursement for bundled services. However, MAA allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for MAA to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1900 Reimbursement—General requirements for physician-related services. (1) MAA reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill MAA according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) MAA does not separately reimburse certain administrative costs or services. MAA considers these costs to be included in the reimbursement. These costs and services include the following:

(a) Delinquent payment fees;

(b) Educational supplies;

(c) Mileage;

(d) Missed or canceled appointments;

(e) Reports, client charts, insurance forms, copying expenses;

(f) Service charges;

(g) Take home drugs; and

(h) Telephoning (e.g., for prescription refills).

(4) MAA does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. MAA reviews these codes for conformance to medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-2000 Increased payments for physician-related services for qualified trauma cases. (1) The department's trauma care fund (TCF) is an amount that is legislatively appropriated to DSHS each biennium for the purpose of increasing the department's payment to eligible physicians and other clinical providers for providing qualified trauma services to medicaid, general assistance-unemployable (GA-U), and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for increased payments from the TCF.

(2) Beginning with services provided after June 30, 2003, the department makes increased payments from the TCF to physicians and other clinical providers who provide trauma services to medicaid, GA-U, and ADATSA clients, subject to the provisions in this section. A provider is eligible to receive increased payments from the TCF for trauma services provided to a GA-U or ADATSA client during the client's certification period only. See WAC 388-416-0010.

(3) The department makes increased payments from the TCF to physicians and other clinical providers who:

(a) Are on the designated trauma services response team of any department of health (DOH)-designated 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; and

(d) Submit all information the department requires to ensure trauma services are being provided.

(4) Except as described in subsection (5) of this section and subject to the limitations listed, the department makes increased payments from the TCF to physicians and other eligible clinical providers:

(a) For only those trauma services that are designated by the department as "qualified." These qualified services must be provided to eligible fee-for-service medicaid, GA-U, and ADATSA clients. Qualified trauma services include care provided within six months of the date of injury for surgical procedures related to the injury if the surgical procedures were planned during the initial acute episode of injury.

(b) For hospital-based services only.

(c) Only for trauma cases that meet the injury severity score (ISS) (a summary rating system for traumatic anatomic injuries) of:

(i) Thirteen or greater for an adult trauma patient (a client age fifteen or older); or

(ii) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).

(d) On a per-client basis in any DOH designated trauma service center.

(e) At a rate of two and one-half times the current department fee-for-service rate for qualified trauma services, or other payment enhancement percentage the department determines as appropriate.

(i) The department monitors the increased payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the biennium will not exceed the legislative appropriation for that biennium.

(ii) Laboratory and pathology charges are not eligible for increased payments from the TCF. (See subsection (6)(b) of this section.)

(5) When a trauma case is transferred from one hospital to another, the department makes increased payments from the TCF to physicians and other eligible clinical providers, according to the ISS score as follows:

(a) If the transferred case meets or exceeds the appropriate ISS threshold described in subsection (4)(c) of this section, eligible providers who furnish qualified trauma services in both the transferring and receiving hospitals are eligible for increased payments from the TCF.

(b) If the transferred case is below the ISS threshold described in subsection (4)(c) of this section, only the eligible providers who furnish qualified trauma services in the receiving hospital are eligible for increased payments from the TCF.

(6) The department distributes increased payments from the TCF only:

(a) When eligible trauma claims are submitted with the appropriate trauma indicator within the time frames specified by the department; and

(b) On a per-claim basis. Each qualifying trauma service and/or procedure on the physician's claim or other clinical provider's claim is paid at the department's current fee-for-service rate, multiplied by an increased TCF payment rate that is based on the appropriate rate described in subsection (4)(e) of this section. Charges for laboratory and pathology services and/or procedures are not eligible for increased payments from the TCF and are paid at the department's current fee-for-service rate.

(7) For purposes of the increased payments from the TCF to physicians and other eligible clinical providers, all of the following apply:

(a) The department may consider a request for a claim adjustment submitted by a provider only if the claim 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 an increased payment from the TCF beyond three

hundred sixty-five days from the date of service. The deadline for making adjustments to a trauma claim for an SFY is the same as the deadline for submitting the initial claim to the department as specified in WAC 388-502-0150(3). 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 increased payments from the TCF disbursed to providers by the department in a biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions are needed to ensure the department stays within the current TCF appropriation (see subsection (4)(e)(i) of this section).

[Statutory Authority: RCW 74.08.090, 74.09.500, and chapter 43.20A RCW. 08-18-029, § 388-531-2000, filed 8/27/08, effective 9/27/08. Statutory Authority: RCW 74.08.090, 74.09.500. 05-20-050, § 388-531-2000, filed 9/30/05, effective 10/31/05; 04-19-113, § 388-531-2000, filed 9/21/04, effective 10/22/04.]

Chapter 388-532 WAC

REPRODUCTIVE HEALTH/FAMILY PLANNING ONLY/TAKE CHARGE

WAC

REPRODUCTIVE HEALTH SERVICES

WAC 388-532-001 Reproductive health services—Purpose. The department of social and health services (DSHS) defines reproductive health services as those services that:

(1) Assist clients to avoid illness, disease, and disability related to reproductive health;

(2) Provide related and appropriate, medically necessary care when needed; and

(3) Assist clients to make informed decisions about using medically safe and effective methods of family planning.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-001, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-001, filed 2/6/04, effective 3/8/04.]

WAC 388-532-050 Reproductive health services—Definitions. The following definitions and those found in WAC 388-500-005, Medical definitions, apply to this chapter.

"Complication"—A condition occurring subsequent to and directly arising from the family planning services received under the rules of this chapter.

"Comprehensive family planning preventive medicine visit"—For the purposes of this program, is a comprehensive, preventive, contraceptive visit which includes:

• An age and gender appropriate history and examination offered to female medicaid clients who are at-risk for unintended pregnancies;

• Education and counseling for risk reduction (ECRR) regarding the prevention of unintended pregnancy; and

• For family planning only and TAKE CHARGE clients, routine gonorrhea and chlamydia testing for women thirteen through twenty-five years of age only.

This preventive visit may be billed only once every twelve months, per client, by a department-contracted TAKE CHARGE provider and only for female clients needing contraception.

"Contraception"—Preventing pregnancy through the use of contraceptives.

"Contraceptive"—A device, drug, product, method, or surgical intervention used to prevent pregnancy.

"Delayed pelvic protocol"—The practice of allowing a woman to postpone a pelvic exam during a contraceptive visit to facilitate initiation or continuation of a hormonal contraceptive method.

"Department"—The department of social and health services.

"Department-approved family planning provider"—A physician, advanced registered nurse practitioner (ARNP), or clinic that has:

• Agreed to the requirements of WAC 388-532-110;

• Signed a core provider agreement with the department;

• Been assigned a unique family planning provider number by the department; and

• Agreed to bill for family planning laboratory services provided to clients enrolled in a department-managed care plan through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA).

"Family planning services"—Medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies.

"Medical identification card"—The document the department uses to identify a client's eligibility for a medical program.

"Natural family planning"—(Also known as fertility awareness method) means methods such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle to identify the fertile days of the menstrual cycle and avoid unintended pregnancies.

"Over-the-counter (OTC)"—See WAC 388-530-1050 for definition.

"Sexually transmitted disease infection (STD-I)"—A disease or infection acquired as a result of sexual contact.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-050, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-050, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-050, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-050, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-050, filed 7/5/00, effective 8/5/00.]

WAC 388-532-100 Reproductive health services—Client eligibility. (1) The department covers limited reproductive health services for clients eligible for the following:

(a) State children's health insurance program (SCHIP);

(b) Categorically needy program (CNP);

(c) General assistance unemployable (GAU) program;

(d) Limited casualty program-medically needy program (LCP-MNP); and

(e) Alcohol and Drug Abuse Treatment and Support Act (ADATSA) services.

(2) Clients enrolled in a department managed care organization (MCO) may self-refer outside their MCO for family planning services (excluding sterilizations for clients twenty-one years of age or older), abortions, and STD-I services to any of the following:

(a) A department-approved family planning provider;

(b) A department-contracted local health department/STD-I clinic;

(c) A department-contracted provider for abortion services; or

(d) A department-contracted pharmacy for:

(i) Over-the-counter contraceptive drugs and supplies, including emergency contraception; and

(ii) Contraceptives and STD-I related prescriptions from a department-approved family planning provider or department-contracted local health department/STD-I clinic.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-100, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-100, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-100, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-100, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-100, filed 7/5/00, effective 8/5/00.]

WAC 388-532-110 Reproductive health services—Provider requirements. To be paid by the department for reproductive health services provided to eligible clients, physicians, ARNPs, licensed midwives, and department-approved family planning providers must:

(1) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Provider rules;

(2) Provide only those services that are within the scope of their licenses;

(3) Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control drugs and supplies and related medical services;

(4) Provide medical services related to FDA-approved prescription birth control methods and OTC birth control drugs and supplies upon request;

(5) Supply or prescribe FDA-approved prescription birth control methods and OTC birth control drugs and supplies upon request;

(6) Refer the client to an appropriate provider if unable to meet the requirements of subsections (3), (4), and (5) of this section[;] and

(7) Refer the client to available and affordable nonfamily planning primary care services, as needed.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-110, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-110, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-110, filed 2/6/04, effective 3/8/04.]

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 388-532-120 Reproductive health—Covered services. In addition to those services listed in WAC 388-531-0100 Physician-related services, the department covers the following reproductive health services:

(1) **Services for women:**

(a) The department covers one of the following per client, per year as medically necessary:

(i) A gynecological examination, billed by a provider other than a TAKE CHARGE provider, which may include a cervical and vaginal cancer screening examination when medically necessary; or

(ii) One comprehensive family planning preventive medicine visit, billable by a TAKE CHARGE provider only. Under a delayed pelvic protocol, the comprehensive family planning preventive medicine visit may be split into two visits, per client, per year. The comprehensive family planning preventive medicine visit must be:

(A) Provided by one or more of the following TAKE CHARGE trained providers:

(I) A physician or physician's assistant (PA);

(II) An advanced registered nurse practitioner (ARNP); or

(III) A registered nurse (RN), licensed practical nurse (LPN), a trained and experienced health educator, medical assistant, or certified nursing assistant when used for assisting and augmenting the clinicians listed in (I) and (II) in subsection (1) of this section.

(B) Documented in the client's chart with detailed information that allows for a well-informed follow-up visit.

(b) Food and Drug Administration (FDA) approved prescription contraception methods as identified in chapter 388-530 WAC, Pharmacy services.

(c) 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 as described in chapter 388-530 WAC, Prescription drugs (outpatient).

(d) Sterilization procedures that meet the requirements of WAC 388-531-1550, if:

(i) Requested by the client; and

(ii) Performed in an appropriate setting for the procedure.

(e) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures.

(f) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(g) Mammograms for clients forty years of age and older, once per year;

(h) Colposcopy and related medically necessary follow-up services;

(i) Maternity-related services as described in chapter 388-533 WAC; and

(j) Abortion.

(2) **Services for men:**

(a) Office visits where the primary focus and diagnosis is contraceptive management and/or there is a medical concern;

(b) Over-the-counter (OTC) contraceptives, drugs and supplies (as described in chapter 388-530 WAC, Prescription drugs (outpatient)).

(c) Sterilization procedures that meet the requirements of WAC 388-531-1550(1), if:

(i) Requested by the client; and

(ii) Performed in an appropriate setting for the procedure.

(d) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures.

(e) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(f) Prostate cancer screenings for men, once per year, when medically necessary.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-120, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-120, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-120, filed 2/6/04, effective 3/8/04.]

WAC 388-532-130 Reproductive health—Noncovered services. Noncovered reproductive health services are the same as shown in WAC 388-531-0150, Noncovered physician-related services—General and administrative.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-130, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-130, filed 2/6/04, effective 3/8/04.]

WAC 388-532-140 Reproductive health services—Reimbursement and payment limitations. (1) The department reimburses providers for covered reproductive health services using the department's published fee schedules.

(2) When a client enrolled in a department-approved managed care plan self-refers outside the plan to either a department-approved family planning provider or a department-contracted local health department STD-I clinic for family planning or STD-I services, all laboratory services must be billed through the family planning provider.

(3) When a client enrolled in a department managed care plan obtains family planning or STD-I services from a department-approved family planning provider or a department-contracted local health department/STD-I clinic which has a contract with the managed care plan, those services must be billed directly to the managed care plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-140, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-140, filed 2/6/04, effective 3/8/04.]

FAMILY PLANNING ONLY PROGRAM

WAC 388-532-500 Family planning only program—Purpose. The purpose of the family planning only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy. The primary goal of the family planning only program is to prevent an unintended, subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This ten-month benefit follows the department's sixty-day postpregnancy coverage. Men are not eligible for the family planning only program.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-500, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-500, filed 2/6/04, effective 3/8/04.]

WAC 388-532-505 Family planning only program—Definitions. The following definition and those found in WAC 388-500-005, Medical definitions and WAC 388-532-050, apply to the family planning only program.

"Family planning only program"—The program that provides an additional ten months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the sixty-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy. This program's coverage is strictly limited to family planning services.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-505, filed 11/30/05, effective 12/31/05.]

WAC 388-532-510 Family planning only program—Client eligibility. A woman is eligible for family planning only services if:

(1) She received medical assistance benefits during her pregnancy; or

(2) She is determined eligible for a retroactive period as defined in WAC 388-500-0005 covering the end of the pregnancy.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-510, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-510, filed 2/6/04, effective 3/8/04.]

WAC 388-532-520 Family planning only program—Provider requirements. To be reimbursed by the department for services provided to clients eligible for the family planning only program, physicians, ARNPs, and/or department-approved family planning providers must:

(1) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Provider rules;

(2) Provide only those services that are within the scope of their licenses;

(3) Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control drugs and supplies and related medical services;

(4) Provide medical services related to FDA-approved prescription birth control methods and OTC birth control drugs and supplies upon request;

(5) Supply or prescribe FDA-approved prescription birth control methods and OTC birth control drugs and supplies upon request;

(6) Refer the client to an appropriate provider if unable to meet the requirements of subsections (3), (4), and (5) of this section; and

(7) Refer the client to available and affordable nonfamily planning primary care services, as needed.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-520, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-520, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-520, filed 2/6/04, effective 3/8/04.]

WAC 388-532-530 Family planning only program—Covered services. The department covers the following services under the family planning only program:

(1) One of the following, per client, per year as medically necessary:

(a) One comprehensive family planning preventive medicine visit billable by a TAKE CHARGE provider only. Under a delayed pelvic protocol, the comprehensive family planning preventive medicine visit may be split into two visits, per client, per year. The comprehensive family planning preventive medicine visit must be:

(I) Provided by one or more of the following TAKE CHARGE trained providers:

(A) Physician or physician's assistant (PA);

(B) An advanced registered nurse practitioner (ARNP); or

(C) A registered nurse (RN), licensed practical nurse (LPN), a trained and experienced health educator, medical assistant, or certified nursing assistant when used for assisting and augmenting the clinicians listed in subsection (A) and (B) of this section.

(II) Documented in the client's chart with detailed information that allows for a well-informed follow-up visit; or

(b) A gynecological examination, billed by a provider other than a TAKE CHARGE provider, which may include a cervical and vaginal cancer screening examination, one per year when it is:

(i) Provided according to the current standard of care; and

(ii) Conducted at the time of an office visit with a primary focus and diagnosis of family planning.

(2) An office visit directly related to a family planning problem, when medically necessary.

(3) Food and Drug Administration (FDA) approved prescription contraception methods meeting the requirements of chapter 388-530 WAC, Prescription drugs (outpatient).

(4) 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 (as described in chapter 388-530 WAC, Prescription drugs (outpatient)).

(5) Sterilization procedure that meets the requirements of WAC 388-531-1550, if it is:

(a) Requested by the client; and

(b) Performed in an appropriate setting for the procedure.

(6) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory test and procedures only when the screening and treatment is:

(a) For chlamydia and gonorrhea as part of the comprehensive family planning preventive medicine visit for women thirteen to twenty-five years of age; or

(b) Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning; and

(c) Medically necessary for the client to safely, effectively, and successfully use, or to continue to use, her chosen contraceptive method.

(7) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-530, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-530, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-530, filed 2/6/04, effective 3/8/04.]

WAC 388-532-540 Family planning only program—Noncovered services. Medical services are not covered under the family planning only program unless those services are:

(1) Performed in relation to a primary focus and diagnosis of family planning; and

(2) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-540, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-540, filed 2/6/04, effective 3/8/04.]

WAC 388-532-550 Family planning only program—Reimbursement and payment limitations. (1) The department limits reimbursement under the family planning only program to visits and services that:

(a) Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and

(b) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

(2) The department reimburses providers for covered family planning only services using the department's published fee schedules.

(3) The department does not cover inpatient services under the family planning only program. However, inpatient charges may be incurred as a result of complications arising directly from a covered family planning service. If this happens, providers of family planning-related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to the department a complete report of the circumstances and conditions that caused the need for the inpatient services.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-550, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-550, filed 2/6/04, effective 3/8/04.]

TAKE CHARGE PROGRAM

WAC 388-532-700 TAKE CHARGE program—Purpose. TAKE CHARGE is a family planning demonstration and research program approved by the federal government under a medicaid program waiver. The purpose of the TAKE CHARGE program is to make family planning services available to men and women with incomes at or below two hundred percent of the federal poverty level. See WAC 388-532-710 for a definition of TAKE CHARGE.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-700, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-700, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-700, filed 10/8/02, effective 11/8/02.]

WAC 388-532-710 TAKE CHARGE program—Definitions. The following definitions and those found in WAC 388-500-0005 medical definitions and WAC 388-532-050 apply to the department's TAKE CHARGE program.

"Ancillary services"—Those family planning services provided to TAKE CHARGE clients by department-contracted providers who are not TAKE CHARGE providers. These services include, but are not limited to, family planning pharmacy services, family planning laboratory services and sterilization services.

"Application assistance"—The process a TAKE CHARGE provider follows in helping a client to complete and submit an application to the department for the TAKE CHARGE program.

"Education, counseling and risk reduction intervention" or **"ECRR"—**Client-centered education and counseling services designed to strengthen decision making skills and support a client's safe, effective and successful use of his or her chosen contraceptive method. For women, ECRR is part of the annual preventive medicine visit. For men, ECRR is a stand alone service for those men seeking family planning services and whose partners are at moderate to high risk of unintended pregnancy.

"TAKE CHARGE"—The department's demonstration and research program approved by the federal government under a medicaid program waiver to provide family planning services.

"TAKE CHARGE provider"—A provider who is approved by the department to participate in TAKE CHARGE by:

(1) Being a department-approved family planning provider; and

(2) Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally approved medicaid waiver for the TAKE CHARGE program.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-710, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-710, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-710, filed 10/8/02, effective 11/8/02.]

WAC 388-532-720 TAKE CHARGE program—Eligibility. (1) The TAKE CHARGE program is for men and women. To be eligible for the TAKE CHARGE program, an applicant must:

(a) Be a United States citizen, U.S. National, or "qualified alien" as described in chapter 388-424 WAC and provide proof of citizenship or qualified alien status, and identity;

(b) Be a resident of the state of Washington as described in WAC 388-468-0005;

(c) Have income at or below two hundred percent of the federal poverty level as described in WAC 388-478-0075;

(d) Need family planning services;

(e) Apply voluntarily for family planning services with a TAKE CHARGE provider; and

(f) Not be currently covered through another medical assistance program for family planning or have any health insurance that covers family planning, except as provided in WAC 388-530-790.

(2) A client who is pregnant or sterilized is not eligible for TAKE CHARGE.

(3) A client is authorized for TAKE CHARGE coverage for one year from the date the department determines eligibility or for the duration of the demonstration and research program, whichever is shorter, as long as the criteria in subsection (1) and (2) of this section continue to be met. Upon reapplication for TAKE CHARGE by the client, the department may renew the coverage for additional periods of up to one year each, or for the duration of the demonstration and research program, whichever is shorter.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-720, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-720, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057, 74.08.090. 04-15-057, § 388-532-720, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-720, filed 10/8/02, effective 11/8/02.]

WAC 388-532-730 TAKE CHARGE program—Provider requirements. (1) A TAKE CHARGE provider must:

(a) Be a department-approved family planning provider as described in WAC 388-532-050;

(b) Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to the department's TAKE CHARGE program guidelines;

(c) Participate in the department's specialized training for the TAKE CHARGE demonstration and research program prior to providing TAKE CHARGE services. Providers must document that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program;

(d) Comply with the required general department and TAKE CHARGE provider policies, procedures, and administrative practices as detailed in the department's billing instructions and provide referral information to clients regarding available and affordable nonfamily planning primary care services;

(e) If requested by the department, participate in the research and evaluation component of the TAKE CHARGE demonstration and research program.

(f) Forward the client's medical identification card and TAKE CHARGE brochure to the client within seven working days of receipt unless otherwise requested in writing by the client;

(g) Inform the client of his or her right to seek services from any TAKE CHARGE provider within the state; and

(h) Refer the client to available and affordable nonfamily planning primary care services, as needed.

(2) Department providers (e.g., pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary TAKE CHARGE services, as defined in this chapter, to eligible [TAKE CHARGE] clients. The department reimburses for these services under the rules and fee schedules applicable to the specific services provided under the department's other programs.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-730, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-730, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.-800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-730, filed 10/8/02, effective 11/8/02.]

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 388-532-740 TAKE CHARGE program—Covered services for women. The department covers the following TAKE CHARGE services for women:

(1) One session of application assistance per client, per year;

(2) Food and Drug Administration (FDA) approved prescription and nonprescription contraceptives as provided in chapter 388-530 WAC, Prescription drugs (outpatient);

(3) 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 (as described in chapter 388-530 WAC, Prescription drugs (outpatient));

(4) One comprehensive family planning preventive medicine visit billable by a TAKE CHARGE provider only. Under a delayed pelvic protocol, the comprehensive family planning preventive medicine visit may be split into two visits, per client, per year. The comprehensive family planning preventive medicine visit must be:

(a) Provided by one or more of the following TAKE CHARGE trained providers:

(i) Physician or physician's assistant (PA);

(ii) An advanced registered nurse practitioner (ARNP); or

(iii) A registered nurse (RN), licensed practical nurse (LPN), a trained and experienced health educator, medical assistant, or certified nursing assistant when used for assisting and augmenting the above listed clinicians.

(b) Documented in the client's chart with detailed information that allows for a well-informed follow-up visit.

(5) Sterilization procedure that meets the requirements of WAC 388-531-1550, if the service is:

(i) Requested by the TAKE CHARGE client; and

(ii) Performed in an appropriate setting for the procedure.

(6) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures, only when the screening and treatment is:

(a) For chlamydia and gonorrhea as part of the comprehensive family planning preventive medicine visit for women thirteen to twenty-five years of age; or

(b) Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning; and

(c) Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

(7) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(8) An office visit directly related to a family planning problem, when medically necessary.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-740, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-740, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.-800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-740, filed 10/8/02, effective 11/8/02.]

WAC 388-532-745 TAKE CHARGE program—Covered services for men. The department covers the following TAKE CHARGE services for men:

(1) One session of application assistance per client, per year;

(2) Over-the-counter (OTC) contraceptives, drugs, and supplies (as described in chapter 388-530 WAC, Prescription Drugs (Outpatient));

(3) Sterilization procedure that meets the requirements of WAC 388-531-1550, if the service is:

(a) Requested by the TAKE CHARGE client; and

(b) Performed in an appropriate setting for the procedure.

(4) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures, only when the screening and treatment is related to, and medically necessary for, a sterilization procedure.

(5) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(6) One education and counseling session for risk reduction (ECRR) per client, every twelve months. ECRR must be:

(a) Provided by one or more of the following TAKE CHARGE trained providers:

(i) Physician or physician's assistant (PA);

(ii) An advanced registered nurse practitioner (ARNP); or

(iii) A registered nurse (RN), licensed practical nurse (LPN), a trained and experienced health educator, medical assistant, or certified nursing assistant when used for assisting and augmenting the clinicians listed in subsection (i) and (ii) of this section; and

(b) Documented in the client's chart with detailed information that allows for a well-informed follow-up visit.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-745, filed 5/13/08, effective 6/13/08.]

WAC 388-532-750 TAKE CHARGE program—Noncovered services. The department does not cover the following medical services under the TAKE CHARGE program:

(1) Abortions and other pregnancy-related services; and

(2) Any other medical services, unless those services are:

(a) Performed in relation to a primary focus and diagnosis of family planning; and

(b) Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-750, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-750, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.-800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-750, filed 10/8/02, effective 11/8/02.]

WAC 388-532-760 TAKE CHARGE program—Documentation requirements. In addition to the documentation requirements in WAC 388-502-0020, TAKE CHARGE providers must keep the following records:

(1) TAKE CHARGE application form(s);

(2) Signed supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE program;

(3) Documentation of the department's specialized TAKE CHARGE training and/or in-house in-service TAKE CHARGE training for each individual responsible for providing TAKE CHARGE.

(4) Chart notes that reflect the primary focus and diagnosis of the visit was family planning;

(5) Contraceptive methods discussed with the client;

(6) Notes on any discussions of emergency contraception and needed prescription(s);

(7) The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan;

(8) Documentation of the education, counseling and risk reduction (ECRR) service, if provided, with sufficient detail that allows for follow-up;

(9) Documentation of referrals to or from other providers;

(10) A form signed by the client authorizing release of information for referral purposes, as necessary;

(11) The client's written and signed consent requesting that his or her medical identification card be sent to the TAKE CHARGE provider's office to protect confidentiality;

(12) A copy of the client's picture identification;

(13) A copy of the documentation used to establish United States citizenship or legal permanent residency; and

(14) If applicable, a copy of the completed DSHS sterilization consent form (DSHS 13-364 - available for download at http://www.dshs.wa.gov/msa/forms/eforms.html) (see WAC 388-531-1550).

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-760, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-760, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.-800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-760, filed 10/8/02, effective 11/8/02.]

WAC 388-532-780 TAKE CHARGE program—Reimbursement and payment limitations. (1) The department limits reimbursement under the TAKE CHARGE program to those services that:

(a) Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and

(b) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

(2) The department reimburses providers for covered TAKE CHARGE services according to the department's published TAKE CHARGE fee schedule.

(3) The department limits reimbursement for TAKE CHARGE research and evaluation activities to selected research sites.

(4) Federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill the department for TAKE CHARGE services without regard to their special rates and fee schedules. The department does not reimburse FQHCs, RHCs or Indian health providers under the encounter rate structure for TAKE CHARGE services.

(5) The department requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, all final billings and billing adjustments related to the TAKE CHARGE program must be completed no later than two years after the demonstration and research program terminates. The department will not accept new billings or billing adjustments that increase expenditures for the TAKE CHARGE program after the cut-off date.

(6) The department does not cover inpatient services under the TAKE CHARGE program. However, inpatient charges may be incurred as a result of complications arising directly from a covered TAKE CHARGE service. If this happens, providers of TAKE CHARGE related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to the department a complete report of the circumstances and conditions that caused the need for inpatient services for the department to consider payment under WAC 388-501-0165.

(7) The department requires a provider under WAC 388-501-0200 to seek timely reimbursement from a third party when a client has available third party resources. The exceptions to this requirement are described under WAC 388-501-0200 (2) and (3) and 388-532-790.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-780, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-780, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.-800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-780, filed 10/8/02, effective 11/8/02.]

WAC 388-532-790 TAKE CHARGE program—Good cause exemption from billing third party insurance. (1) TAKE CHARGE applicants who are eighteen years of age or younger and depend on their parents' medical insurance, or individuals who are domestic violence victims who depend on their spouses or another's health insurance may request an exemption, due to "good cause," from the eligibility restrictions in WAC 388-532-720 (1)(f) and from the use of available third party family planning coverage. Under the TAKE CHARGE program, "good cause" means that use of the third party coverage would violate his or her confidentiality because the third party:

(a) Routinely or randomly sends verification of services to the third party subscriber and that subscriber is other than the applicant; and/or

(b) Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to the subscriber.

(2) If subsection (1)(a) or (1)(b) of this section applies, the applicant is eligible for TAKE CHARGE without regard to the available third party family planning coverage.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 08-11-031, § 388-532-790, filed 5/13/08, effective 6/13/08. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-790, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-790, filed 10/8/02, effective 11/8/02.]

Chapter 388-533 WAC
MATERNITY-RELATED SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-533-0350 Maternity case management. [Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-533-0350, filed 11/16/00, effective 12/17/00.] Repealed by 04-13-049, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910.

388-533-0500 Planned home births—Pilot project. [Statutory Authority: RCW 74.08.090. 00-24-054, § 388-533-0500, filed 11/30/00, effective 12/31/00.] Repealed by 05-01-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770.

WAC 388-533-0300 Enhanced benefits for pregnant women. Pursuant to the 1989 Maternity Care Access Act, also known as First Steps, the medical assistance administration (MAA) provides enhanced services to eligible women during and after their pregnancy. The enhanced services include:

(1) Maternity support services (see WAC 388-533-0310 through 388-533-0345;

(2) Infant case management services (see WAC 388-533-0360 through 388-533-0386);

(3) Alcohol and drug assessment and treatment services (see WAC 388-533-0701);

(4) Childbirth education classes (see WAC 388-533-0390); and

(5) Childcare services (see WAC 388-533-1000).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0300, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

MATERNITY SUPPORT SERVICES

WAC 388-533-0310 Maternity support services—Purpose. The integrated maternity support services (MSS) program provides enhanced preventive health and education services to eligible pregnant women and their families during the maternity cycle. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs. MSS is collaboratively managed by the department of health and the medical assistance administration. This MSS program combines the previous MSS and maternity case management programs.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0310, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0315 Maternity support services—Definitions. The following definitions and those found in WAC 388-500-0005 apply to the maternity support services (MSS) program.

"Advocacy"—For the purposes of the MSS program, means actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

"Assurances document"—A signed agreement documenting that the provider understands and agrees to maintain certain required program elements; and to work toward integrating other specifically recommended practices. Also referred to as the MSS/ICM assurances document.

"Basic health messages"—For the purposes of the MSS program, means the preventative health education messages designed to promote healthy pregnancies, healthy newborns and healthy parenting during the first year of life.

"Case management"—For the purposes of the MSS program, means services to assist individuals who are eligible under the medicaid state plan, to gain access to needed medical, social, educational, and other services.

"Childbirth education classes (CBE)"—A series of educational sessions offered in a group setting and led by an approved instructor to prepare a pregnant woman and her support person for an upcoming childbirth.

"Childcare"

"DASA (division of alcohol and substance abuse)"—Childcare for women attending DASA-funded outpatient alcohol or drug treatment services that may be provided through the treatment facility.

"First Steps"—Childcare funded through the First Steps Program for the care of children of pregnant or post-

pregnant women who are attending appointments for medicaid-covered services, pregnant women on physician ordered bed rest, and for visits to the neonatal intensive care unit (NICU) after delivery.

"Community and family health (CFH)"—Refers to the division within the state department of health whose mission is to improve the health and well-being of Washington residents with a special focus on infants, children, youth, pregnant woman, and prospective parents.

"Consultation"—For the purposes of the MSS program, means the practice of conferring with other professionals to share knowledge and problem solve with the intent of providing the best possible care to clients.

"Core services"—For the purposes of the MSS program, means the services that provide the framework for interdisciplinary, client-centered maternity support services and infant case management. These services include: Client screening, basic health messages, basic linkages, and minimum interventions.

"Department of health (DOH)"—The agency whose mission is to protect and improve the health of people in Washington state.

"Department of social and health services (DSHS)"—The state agency that administers social and health services programs for the state of Washington.

"First Steps"—The 1989 Maternity Care Access Act, known as First Steps. This program provides enhanced maternity care for pregnant and postpregnant women, and health care for infants. The program is managed collaboratively by DSHS and DOH. First Steps maternity care consists of obstetrical care, maternity support services, childbirth education classes, and infant case management.

"First Steps Childcare"—See childcare.

"Home visit"—For the purposes of the MSS program, means services delivered in the client's place of residence or other setting as described in the medical assistance administration's published MSS/ICM billing instructions.

"Infant case management (ICM)"—A program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the infant's first birthday.

"Interagency agreement"—A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients).

"Interdisciplinary team"—Members from different professions and occupations that work closely together and communicate frequently to optimize care for the client (pregnant woman and infant). Each team member contributes specialized knowledge, skills and experience to support and augment the contributions of the other team members.

"Linkages"—Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

"Maternal and infant health (MIH)"—A section within the state department of health. MIH works collaboratively with DSHS to provide clinical consultation, oversight and monitoring of the MSS/ICM programs.

"Maternity cycle"—An eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day postpregnancy occurs.

"Maternity support services (MSS)"—Preventive health services for pregnant/postpregnant women including: Professional observation, assessment, education, intervention and counseling. MSS services are provided by an interdisciplinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist. Additional MSS services may be provided by community health workers.

"Medical assistance administration (MAA)"—The administration within DSHS authorized to administer medical assistance programs.

"Minimum interventions"—Defined levels of client assessment, education, intervention and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services.

"Performance measure"—An indicator used to measure the results of a focused intervention or initiative.

"Risk factors"—The biopsychosocial factors that could lead to negative pregnancy or parenting outcomes. The MSS/ICM program design identifies specific risk factors and corresponding minimum interventions.

"Service plan"—The written plan of care that must be developed and maintained throughout the eligibility period for each client in the MSS/ICM programs.

"Staff"—For the purposes of the MSS program, means the personnel employed by providers.

"Unit of service"—Fifteen minutes of one-to-one service delivered face-to-face.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0315, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0320 Maternity support services—Client eligibility. (1) To be eligible for maternity support services (MSS), a client must be:

(a) Covered under one of the following medical assistance administration programs:

(i) Categorically needy program (CNP);

(ii) Categorically needy program—Children's health insurance program; (CNP-Children's health insurance program); or

(iii) Categorically needy program—Emergency medical only (CNP-Emergency medical only); and

(b) Pregnant or still within the maternity cycle.

(2) Clients meeting the eligibility criteria in WAC 388-533-0320(1) who are enrolled in an MAA managed care plan, are eligible for MSS services outside their plan. MSS services delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0320, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0325 Maternity support services—Provider requirements. (1) Services under this program are provided only by approved maternity support services (MSS)/infant case management (ICM) providers. Representatives from the medical assistance administration (MAA)

and the department of health (DOH) recruit and approve providers using the following criteria:

(a) Services are to be delivered in area of geographic need as determined by MAA/DOH; and

(b) Providers must:

(i) Deliver both MSS and ICM services;

(ii) Provide services in both office and home visit settings; and

(iii) Assure maintenance of staffing requirements and delivery of core services according to program design.

(2) To participate in the MSS program, a provider must:

(a) Comply with the clinical supervision/clinical consultation guidelines as required in the assurances document;

(b) Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;

(c) Ensure that all newly hired staff receive an orientation to First Steps as soon as possible, but no later than sixty days from the hire date;

(d) Refer clients who may need chemical dependency assessment and/or treatment to a provider contracted with the division of alcohol and substance abuse (DASA) (see chapter 440-22 WAC);

(e) Authorize First Steps childcare for the MSS client as appropriate to facilitate MSS and First Step objectives (see WAC 388-533-1000 for rules governing First Steps childcare);

(f) Complete and document case conferencing activities.

(3) To be reimbursed by MAA for MSS, providers must:

(a) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Providers rules;

(b) Have a completed, approved MSS/ICM assurance document, signed by an officer or employee qualified to sign on behalf of the provider, on file with MAA;

(c) Meet the DOH/MAA requirements for a qualified MSS interdisciplinary team as prescribed in the assurances document;

(d) Ensure that staff meet the minimum qualifications for the MSS rules they perform; and

(e) Submit billings as instructed in MAA's published MSS/ICM billing instructions.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0325, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0330 Maternity support services—Covered services. (1) The medical assistance administration (MAA) covers services under the maternity support services (MSS) program subject to the restrictions and limitations in this section and other applicable published WAC.

(2) Covered services include:

(a) Community health nursing visits;

(b) Nutrition visits;

(c) Behavioral health visits; and

(d) Community health worker visits under the direction of a professional member of the team.

(3) The services listed in WAC 388-533-0330(2) are covered under this program only when the services are:

(a) Documented in the client's record;

(b) Provided on an individual basis in a face-to-face encounter;

(c) Delivered by a qualified staff person acting within her/his area of expertise; and

(d) Used for the purposes of the MSS program to provide:

(i) Risk screening;

(ii) Education that relates to improving pregnancy and parenting outcomes;

(iii) Brief counseling;

(iv) Interventions for identified risk factors;

(v) Basic health messages;

(vi) Referral and linkages to other services; or

(vii) Family planning screening.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0330, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0340 Maternity support services—Noncovered services. (1) The following are considered noncovered services under the MSS program. Any service:

(a) Not within the scope of the program;

(b) Not listed in WAC 388-533-0330; or

(c) Any service provided by staff not qualified to deliver the service.

(2) The department evaluates requests for services listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-533-0340, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0340, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0345 Maternity support services—Reimbursement. Services provided under the maternity support services (MSS) program are reimbursed on a fee-for-service basis subject to the following limitations:

(1) MAA reimburses under this program only for services billed using approved procedure codes and modifiers as identified in MAA's published MSS/ICM billing instructions;

(2) MAA reimburses MSS services in units of time with one unit being equal to fifteen minutes of service;

(3) MAA reimburses a maximum of:

(a) Six units per client, per day for any combination of office or home visits;

(b) Sixty total units per client, from all disciplines, over the maternity cycle;

(c) A one-time-only fee per client for the family planning performance measure; and

(d) A one-time-only fee per client per pregnancy for the tobacco cessation performance measure.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0345, filed 6/10/04, effective 7/11/04.]

INFANT CASE MANAGEMENT SERVICES

WAC 388-533-0360 Infant case management—Purpose. The infant case management (ICM) program serves high-risk infants and their families. The goal of ICM is to improve self-sufficiency of the parent(s) in gaining access to needed medical, social, educational, and other services (SSA 1915(g)).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0360, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0365 Infant case management—Definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions and 388-533-0315, Maternity support services definitions apply to this section:

"Infant case management (ICM)"—The program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle up to the end of the month of the baby's first birthday.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0365, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0370 Infant case management—Eligibility. (1) To be eligible for infant case management (ICM):

(a) The infant must be covered under one of the medical programs listed in WAC 388-533-0320 (1)(a) of this chapter;

(b) The parent(s) must need assistance in accessing or providing care for the infant; and

(c) At least one or more of the following criteria exists:

(i) The parent(s) are unable to care for infant specifically due to at least one of the following:

(A) Incarceration of the mother within the last year;

(B) Low functioning ability (e.g., needs repeated instructions, not attuned to infant cues, leaves infant with inappropriate caregivers, parent has the equivalent of less than an eighth grade education);

(C) Unstable mental health issue (regardless of whether the mental health issue is being treated or not);

(D) Physical impairment;

(E) Infant's mother is experiencing postpregnancy depression or mood disorder or has a history of depression/mood disorder;

(F) Infant's parent(s) are unable to access resources due to age (nineteen years of age or younger);

(G) Social isolation (e.g., family is new to the community, parent(s) do not have a support system, family moves frequently, lack of supportive living environment);

(H) Inability to access resources due to language or cultural barrier.

(ii) The infant's safety is a concern specifically due to at least one of the following:

(A) Domestic or family violence in present or past relationship that keeps the parent(s) feeling unsafe;

(B) Substance abuse by the infant's mother and/or father that is impacting ability to parent;

(C) Secondhand smoke exposure to the infant;

(D) Child protective service involvement within the last year or mother/father had parental rights terminated in the past;

(E) Unstable living situation (e.g., homelessness, couch surfing, unsafe conditions, no cooking facilities, heat, or water).

(iii) The infant's health is a concern specifically due to at least one of the following:

(A) Low birth weight—less than five and one half pounds;

(B) Premature birth—less than thirty-seven weeks gestation;

(C) Failure to thrive (e.g., baby is not gaining weight, significant feeding difficulty, no eye contact, or baby is listless);

(D) Multiple births (twins, triplets. etc.);

(E) Excessive fussiness or infant has irregular sleeping patterns (e.g., parent(s)' sleep deprivation, exhaustion and/or need for respite childcare);

(F) Infant has an identified medical problem or disability.

(2) Clients meeting the eligibility criteria in WAC 388-533-0370(1) who are enrolled in an MAA managed care plan are eligible for ICM services outside their plan. ICM services delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0370, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0375 Infant case management—Provider requirements. (1) Services under this program are provided only by approved integrated maternity support services (MSS)/infant case management (ICM) providers. Representatives from the department of health (DOH) and the department of social and health services' (DSHS) medical assistance administration (MAA) recruit and approve providers using the following criteria:

(a) Services are to be delivered in area of geographic need as determined by MAA/DOH; and

(b) Provider must:

(i) Deliver both MSS and ICM services;

(ii) Provide services in both office and home visit settings; and

(iii) Assure maintenance of staffing requirements and delivery of service according to program design.

(2) To participate in the ICM program, a provider must:

(a) Comply with the clinical supervision/clinical guidelines as prescribed in the assurances document;

(b) Notify the MAA program manager when there is a staff change in a designated position;

(c) Ensure that all newly hired staff receive an orientation to First Steps services as soon as possible, but not later than sixty days from the hire date; and

(d) Submit billings as instructed in MAA's published MSS/ICM billing instructions.

(3) To be reimbursed by MAA for ICM, a provider must:

(a) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Providers rules;

(b) Have a completed, approved MSS/ICM assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with MAA; and

(c) Ensure that staff meet the minimum qualifications for the ICM roles they perform.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0375, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0380 Infant case management—Covered services. (1) The medical assistance administration (MAA) covers services under the infant case management (ICM) program subject to the restrictions and limitations in this section and other applicable published WAC.

(2) The ICM program reimburses approved providers for case management including:

(a) Assessing risk and need;

(b) Reviewing and updating the infant and parent(s) service plan;

(c) Referring and linking the client to other agencies; and

(d) Advocating for the client with other agencies.

(3) The case management activities listed in WAC 388-533-0380(2) are covered under the ICM program only when:

(a) Documented in the client's record;

(b) Provided on an individual basis in a face-to-face encounter;

(c) Performed by a qualified staff person acting within her/his area of expertise; and

(d) Provided according to program design as described in the MSS/ICM assurances document.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0380, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0385 Infant case management—Noncovered services. (1) The following services are noncovered under the infant case management (ICM) program:

(a) Any direct delivery of services other than case management activities listed in WAC 388-533-0380(2); and

(b) Any service provided by staff not qualified to deliver the service.

(2) The department evaluates requests for services listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-533-0385, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0385, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0386 Infant case management services—Reimbursement. The medical assistance administration (MAA) reimburses for infant case management (ICM) services on a fee-for-service basis subject to the following terms and limitations:

(1) ICM is reimbursed in units of service with one unit being equal to fifteen minutes of service;

(2) MAA reimburses:

(a) No more than six ICM units per month, per client; and

(b) No more than forty ICM units total per client through the end of the month of the baby's first birthday; and

(c) Only for services billed using the approved ICM procedure code and modifier identified in MAA's published MSS/ICM billing instructions.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0386, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0390 Childbirth education classes (CBE). (1) Purpose. The childbirth education services described in this section are intended to help prepare the pregnant client and her support person for labor and delivery.

(2) Definitions. The following definitions apply to WAC 388-533-0390:

(a) Approved instructor—A childbirth instructor meeting specific criteria set by the Washington department of health (DOH) maternal and infant health section and approved by the DOH health education consultant to provide childbirth education to pregnant clients.

(b) Childbirth education classes (CBE)—A series of educational sessions offered in a group setting; with a minimum of eight hours of instruction and led by an approved instructor to prepare a pregnant woman and her support person for an upcoming childbirth.

(c) Social services payment systems (SSPS)—The payment method used by the department of social and health services (DSHS) for certain social services and independent providers.

(3) Client eligibility. Childbirth education classes under WAC 388-533-0390 are available to women who are:

(a) Pregnant; and

(b) Covered under one of the following medical assistance administration (MAA) programs:

(i) Categorically needy program (CNP);

(ii) Categorically needy program—Children's health insurance program; (CNP-Children's health insurance program); or

(iii) Categorically needy program emergency medical only (CNP-Emergency medical only).

(4) Provider requirements. A childbirth educator providing services under WAC 388-533-0390 must:

(a) Be an approved CBE provider (individual or agency) with an assigned SSPS/CBE billing number, and a signed program assurances document on file with MAA;

(b) Deliver CBE services in group sessions;

(c) Bill the medical assistance administration (MAA):

(i) Using the assigned SSPS/CBE billing number; and

(ii) According to the form and instruction requirements in MAA's CBE billing instructions; and

(d) Accept the MAA fee as final and complete payment for a client.

(5) Covered services. MAA covers childbirth education when the instruction is:

(a) Provided to clients eligible under WAC 388-533-0390(3);

(b) Delivered in group sessions with a minimum of eight hours of instruction; and

(c) Delivered according to a curriculum approved by the MAA/DOH program managers.

(6) Noncovered services. The following are considered noncovered services under childbirth education:

(a) Any services beyond the scope of CBE; and

(b) Any education about childbirth that is provided during a one-to-one home or office visit. (CBE provided in a one-to-one home or office visit must be billed according to WAC 388-533-0340 and 388-533-0345, Maternity support services rules.)

(7) Reimbursement. MAA reimburses CBE services subject to the following terms and limitations:

(a) Reimbursement:

(i) Is limited to one series per client, per pregnancy;

(ii) Must be for the clients specifically enrolled in the session; and

(iii) Includes all classes, core materials, publications and educational materials provided throughout the class series. (MAA clients must receive the same materials as are offered to other attendees.)

(b) A client must attend at least one CBE session in order for the provider to be reimbursed for the CBE services to the client.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0390, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

(a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.

(b) **"Bundled services"** means services integral to the major procedure that are included in the fee for the major procedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

(c) **"Facility fee"** means the portion of MAA's payment for the hospital or birthing center charges. This does not include MAA's payment for the professional fee defined below.

(d) **"Global fee"** means the fee MAA pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) **"High-risk"** pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) **"Professional fee"** means the portion of MAA's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 388-531-1850 for reimbursement methodology.)

(2) MAA covers full scope medical maternity care and newborn delivery services to fee-for-service clients who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility). Clients enrolled in an MAA managed care plan must receive all medical maternity care and newborn delivery services through the plan. See subsection (20) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

(3) MAA does not provide maternity care and delivery services to its clients who are eligible for:

(a) Family planning only (a pregnant client under this program should be referred to the local community services office for eligibility review); or

(b) Any other program not listed in this section.

(4) MAA requires providers of maternity care and newborn delivery services to meet all of the following. Providers must:

(a) Be currently licensed by the state of Washington's department of health (DOH) and/or department of licensing;

(b) Have signed core provider agreements with MAA;

(c) Be practicing within the scope of their licensure; and

(d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA), etc.).

(5) MAA covers total obstetrical care services (paid under a global fee). Total obstetrical care includes all of the following:

(a) Routine antepartum care that begins in any trimester of a pregnancy;

(b) Delivery (intrapartum care/birth) services; and

(c) Postpartum care. This includes family planning counseling.

(6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, MAA pays that provider a global obstetrical fee.

(7) When an eligible client receives services from more than one provider, MAA pays each provider for the services furnished. The separate services that MAA pays appear in subsection (5) of this section.

(8) MAA pays for antepartum care services in one of the following two ways:

(a) Under a global fee; or

(b) Under antepartum care fees.

(9) MAA's fees for antepartum care include all of the following:

(a) Completing an initial and any subsequent patient history;

(b) Completing all physical examinations;

(c) Recording and tracking the client's weight and blood pressure;

(d) Recording fetal heart tones;

(e) Performing a routine chemical urinalysis (including all urine dipstick tests); and

(f) Providing maternity counseling.

(10) MAA covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section. MAA pays separately for any of the following:

(a) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). MAA provides a list of diagnoses and/or conditions that MAA identifies as justifying more frequent monitoring visits. MAA pays for either (a) or (b) of this subsection, but not both;

(b) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife. MAA pays for either (a) or (b) of this subsection, but not both;

(c) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and/or

(d) Treatment of medical problems that are not related to the pregnancy. MAA pays these fees to physicians or advanced registered nurse practitioners (ARNP).

(11) MAA covers high-risk pregnancies. MAA considers a pregnant client to have a high-risk pregnancy when the client:

(a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or

(b) Has a diagnosis of multiple births.

(12) MAA covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.

(13) MAA pays a facility fee for delivery services in the following settings:

(a) Inpatient hospital; or

(b) Birthing centers.

(14) MAA pays a professional fee for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;

(b) Planned home births and birthing centers.

(15) MAA covers hospital delivery services for an eligible client as defined in subsection (2) of this section. MAA's

bundled payment for the professional fee for hospital delivery services include:

(a) The admissions history and physical examination; and

(b) The management of uncomplicated labor (intrapartum care); and

(c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or

(d) Cesarean delivery of the newborn.

(16) MAA pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(17) In addition to MAA's payment for professional services in subsection (15) of this section, MAA may pay separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery and/or newborn resuscitation;

(b) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;

(c) A physician, (ARNP), or licensed midwife for newborn examination as the delivery setting allows; and/or

(d) An obstetrician/gynecologist specialist for external cephalic version and consultation.

(18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, MAA allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. MAA's typical payment covers delivery of the first child. For each subsequent child, MAA pays at fifty percent of the provider's usual and customary charge, up to MAA's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(19) MAA does not pay separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. MAA's cesarean section surgery fee covers one or multiple surgical births;

(b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as or part of postpartum care.

(20) In addition to the services listed in subsection (10) of this section, MAA covers counseling for tobacco dependency for eligible pregnant women through two months postpregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) MAA covers smoking cessation counseling for only those fee-for-service clients who are eligible for categorically needy (CN) scope of care. See (f) of this subsection for limitations on prescribing pharmacotherapy for eligible CN clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.

(b) MAA pays a fee to certain providers who include smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). MAA pays only the following providers for smoking cessation counseling:

(i) Physicians;

(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;

(iii) ARNPs, including certified nurse midwives (CNM); and

(iv) Licensed midwives (LM).

(c) MAA covers one smoking cessation counseling session per client, per day, up to ten sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information in (e) of this subsection.

(d) MAA covers two levels of counseling. Counseling levels are:

(i) Basic counseling (fifteen minutes), which includes (e)(i), (ii), and (iii) of this subsection; and

(ii) Intensive counseling (thirty minutes), which includes the entirety of (e) of this subsection.

(e) Smoking cessation counseling consists of providing information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to MAA's physician-related services billing instructions and births and birthing centers billing instructions for specific counseling suggestions and billing requirements):

(i) Asking the client about her smoking status;

(ii) Advising the client to stop smoking;

(iii) Assessing the client's willingness to set a quit date;

(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see (f) of this subsection); and

(v) Arranging to track the progress of the client's attempt to stop smoking.

(f) A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

(i) MAA covers Zyban™ only;

(ii) The product must meet the rebate requirements described in WAC 388-530-1125;

(iii) The product must be prescribed by a physician, ARNP, or physician assistant;

(iv) The client for whom the product is prescribed must be eighteen years of age or older;

(v) The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and

(vi) The prescribing provider must include both of the following on the client's prescription:

(A) The client's estimated or actual delivery date; and

(B) Indication the client is participating in smoking cessation counseling.

(g) MAA's payment for smoking cessation counseling is subject to postpay review. See WAC 388-502-0230, Provider review and appeal, and WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for information regarding review and appeal processes for providers.

[Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. 05-01-065, § 388-533-0400, filed 12/8/04, effective 1/8/05; 02-07-043, § 388-533-0400, filed 3/13/02, effective 4/13/02. Statutory Authority: RCW 74.08.090,

74.09.760 through 74.09.800. 00-23-052, § 388-533-0400, filed 11/13/00, effective 12/14/00.]

WAC 388-533-0600 Planned home births and births in birthing centers. (1) MAA covers planned home births and births in birthing centers for its clients when the client and the maternity care provider choose to have a home birth or to give birth in an MAA-approved birthing center and the client:

(a) Is eligible for CN or MN scope of care (see WAC 388-533-400(2));

(b) Has a MAA-approved medical provider who has accepted responsibility for the planned home birth or birth in birthing center as provided in this section;

(c) Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and

(d) Passes MAA's risk screening criteria. MAA provides these risk-screening criteria to qualified medical services providers.

(2) MAA approves only the following provider types to provide MAA-covered planned home births and births in birthing centers:

(a) Physicians licensed under chapters 18.57 or 18.71 RCW;

(b) Nurse midwives licensed under chapter 18.79 RCW; and

(c) Midwives licensed under chapter 18.50 RCW.

(3) Each participating birthing center must:

(a) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC;

(b) Be specifically approved by MAA to provide birthing center services;

(c) Have a valid core provider agreement with MAA; and

(d) Maintain standards of care required by DOH for licensure.

(4) MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in subsection (3) of this section.

(5) Home birth or birthing center providers must:

(a) Obtain from the client a signed consent form in advance of the birth;

(b) Follow MAA's risk screening criteria and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;

(c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client and/or newborn to a hospital;

(d) Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care;

(e) Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to the department of health for testing; and

(f) Have evidence of current cardiopulmonary resuscitation (CPR) training for:

(i) Adult CPR; and

(ii) Neonatal resuscitation.

(6) Planned home providers must:

(a) Provide medically necessary equipment, supplies, and medications for each client;

(b) Have arrangements for twenty-four hour per day coverage;

(c) Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and

(d) Participate in a formal, state-sanctioned, quality assurance/improvement program or professional liability review process (e.g., Joint Underwriting Association (JUA), Midwives Association of Washington State (MAWS), etc.).

(7) MAA does not cover planned home births or births in birthing centers for women identified with any of the following conditions:

(a) Previous cesarean section;

(b) Current alcohol and/or drug addiction or abuse;

(c) Significant hematological disorders/coagulopathies;

(d) History of deep venous thromboses or pulmonary embolism;

(e) Cardiovascular disease causing functional impairment;

(f) Chronic hypertension;

(g) Significant endocrine disorders including preexisting diabetes (type I or type II);

(h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;

(i) Isoimmunization, including evidence of Rh sensitization/platelet sensitization;

(j) Neurologic disorders or active seizure disorders;

(k) Pulmonary disease;

(l) Renal disease;

(m) Collagen-vascular diseases;

(n) Current severe psychiatric illness;

(o) Cancer affecting site of delivery;

(p) Known multiple gestation;

(q) Known breech presentation in labor with delivery not imminent; or

(r) Other significant deviations from normal as assessed by the provider.

[Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. 05-01-065, § 388-533-0600, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0600, filed 11/13/00, effective 12/14/00.]

WAC 388-533-0701 Chemical-using pregnant (CUP) women program—Purpose. The chemical-using pregnant (CUP) women program provides immediate access to medical care in a hospital setting to chemical-using or chemical-dependent pregnant women and their fetuses. The purpose of the immediate access to medical care is to reduce harm to and improve birth outcomes for mothers and their fetuses by preventing obstetric and prenatal complications related to chemical dependency.

[Statutory Authority: RCW 74.08.090, 74.09.800. 04-11-008, § 388-533-701 (codified as WAC 388-533-0701), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0710 Chemical-using pregnant (CUP) women program—Client eligibility. (1) To be eligible for the chemical-using pregnant (CUP) women program, a woman must meet all of the following conditions:

(a) Be pregnant; and

(b) Be eligible for medicaid.

(2) Clients meeting the eligibility criteria in WAC 388-533-0710(1) who are enrolled in an MAA managed care plan are eligible for CUP services outside their plan, except Washington medicaid integration partnership clients. CUP services delivered outside the managed care plan are reimbursed and subject to the same program rules as apply to nonmanaged care clients.

(3) Clients receiving three-day or five-day detoxification services through the department are not eligible for the CUP women program.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0710, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-710 (codified as WAC 388-533-0710), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0720 Chemical-using pregnant (CUP) women program—Provider requirements. (1) The medical assistance administration (MAA) pays only those providers who:

(a) Have been approved by MAA to provide chemical-using pregnant (CUP) women program services;

(b) Have been certified as chemical dependency service providers by the division of alcohol and substance abuse (DASA) as prescribed in chapter 388-805 WAC;

(c) Meet the hospital standards prescribed by the Joint Commission on Accreditation of Healthcare Organizations (JCACHO);

(d) Meet the general provider requirements in chapter 388-502 WAC; and

(e) Are not licensed as an institution for mental disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

(2) CUP women program service providers are required to:

(a) Report any changes in their certification, level of care, or program operations to the MAA CUP women program manager;

(b) Have written policies and procedures that include a working statement describing the purpose and methods of treatment for chemical-using/abusing pregnant women;

(c) Provide guidelines and resources for current medical treatment methods by specific drug and/or alcohol type;

(d) Have linkages with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and

(e) Ensure that a chemical dependency assessment of the client has been completed:

(i) By a chemical dependency professional as defined in chapter 246-811 WAC;

(ii) Using the latest criteria of the American Society of Addiction Medicine (ASAM); and

(iii) No earlier than six months before, and no later than five days after, the client's admission to the CUP women program.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0720, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-720 (codified as WAC 388-533-0720), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0730 Chemical-using pregnant (CUP) women program—Covered services. (1) The medical assistance administration (MAA) pays for the following covered services for a pregnant client and her fetus under the chemical-using pregnant (CUP) women program:

(a) Primary acute detoxification/medical stabilization;

(b) Secondary subacute detoxification/medical stabilization; and

(c) Rehabilitation treatment and services as determined by the provider.

(2) The maximum length of treatment per inpatient stay that MAA will pay for is twenty-six days, unless additional days have been preauthorized by the MAA CUP women program manager.

(3) If a client's pregnancy ends before inpatient treatment is completed, a provider may continue the client's treatment through the twenty-sixth day.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0730, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-730 (codified as WAC 388-533-0730), filed 5/5/04, effective 6/5/04.]

WAC 388-533-1000 First steps child care program. The purpose of the first steps child care program is to fund child care for children so that their pregnant or postpregnant mothers can access prenatal care or other medical assistance administration (MAA)-covered services.

(1) For the purposes of this section, the following terms and definitions apply:

(a) **"Background check central unit (BCCU)"** means the centralized unit established by the department of social and health services (DSHS) that performs background checks as directed by the Washington state legislature.

(b) **"Finding"** means an action taken by the department of social and health services (DSHS) that shows an individual or entity has been found by the department to have abused, neglected, exploited or abandoned a vulnerable person. Findings reported by DSHS or the background check central unit (BCCU) or both are limited to official findings that have been established through legal due process or an administrative hearing process or both.

(c) **"First steps agency"** means an entity, public or private, that is contracted with the medical assistance administration (MAA) to provide first steps program services.

(d) **"MAA first steps child care authorizers"** or **"authorizers"** means the individuals eligible to authorize first steps child care through the first steps child care program. Authorizers include maternity support services (MSS) professional/paraprofessional agency staff members, community services office (CSO) social workers or designated staff members, and other MAA-designated professional/paraprofessional persons.

(e) **"MAA first steps child care coordinator or designee"** means the individual designated by MAA to review special needs requests for first steps child care through the first steps child care program.

(f) **"MAA first steps child care program manager"** means the individual designated by MAA to review all background check cases identified by the background check central unit (BCCU) as "needing further review."

(g) **"Postpregnancy"** means the period of time after the pregnancy ends (includes live birth, still birth, miscarriage, or pregnancy termination) through the end of the month that includes the sixtieth day from the end of the pregnancy.

(2) First steps child care is available for the children of either a managed care or fee-for-service client. Subject to the restrictions and limitations listed in this section, a client is eligible to receive first steps child care for her children if she:

(a) Meets one of the following criteria:

(i) Is pregnant; or

(ii) Is within the postpregnancy period.

(b) Is currently eligible under one of the following programs:

(i) Categorically needy program (CNP);

(ii) CNP - emergency medical only; or

(iii) Children's health insurance program (CHIP).

(c) Requires one or more of the covered services listed in subsection (4) and (5) of this section;

(d) Demonstrates a need for child care; and

(e) Shows that no other child care resources are available.

(3) The following persons are eligible to authorize first steps child care, subject to the restrictions and limitations in this chapter and other WAC:

(a) Maternity support services (MSS) professional/paraprofessional agency staff members. See WAC 388-533-0300 (3) and (7);

(b) Community services office (CSO) social workers or designated staff members; and

(c) Other MAA-designated professional/paraprofessional persons.

(4) First steps child care may be authorized for a client's child(ren) during the client's pregnancy or postpregnancy period when the client pursues any of the following covered services for herself or her newborn children:

(a) Childbirth education classes;

(b) Delivery/birth (during the mother's hospitalization);

(c) Dental care;

(d) Hospital procedures;

(e) Laboratory tests;

(f) Maternity support services (MSS) visits, including nursing, social work, nutrition, and community health worker visits;

(g) Medical visits; and

(h) Family planning services.

(5) First steps child care authorized for a client's child(ren) for the following special needs requires approval by the MAA first steps child care coordinator or designee prior to providing the child care (see subsection (6) of this section for the prior approval process):

(a) Bedrest for the pregnant client for any of the following reasons:

(i) Preterm labor, with evidence of cervical change or very high risk clinically or historically for preterm delivery;

(ii) Incompetent cervix;

(iii) Bleeding (abruption, placentia previa, etc.);

(iv) Preterm ruptured membranes;

(v) Intrauterine growth restriction;

(vi) Oligohydramnios;

(vii) Multiple gestations; or

(viii) Other reasons if the obstetrical provider provides a complete clinical description of the client's circumstance (this special request for bedrest must be faxed to the MAA first steps child care coordinator or designee).

(b) The newborn(s) is in a neonatal intensive care unit (NICU) and the parent(s) is visiting the NICU.

(6) The prior approval process for a request for first steps child care for either of the reasons stated in subsection (5) of this section is as follows:

(a) The authorizer completes appropriate sections of the first steps child care billing form (DSHS 14-316) and submits the form to the MAA first steps child care coordinator or designee.

(i) If bedrest is required for a pregnant client due to one of the reasons listed in subsection (5)(a) of this section, the authorizer documents in the client's file the reason for the bedrest and that the prenatal caregiver has verified that bedrest is necessary; or

(ii) If the reason for the request is to enable a parent(s) to visit the newborn(s) in a NICU, the authorizer documents in the client's file that hospital staff member has verified the parent(s) is visiting the newborn(s) regularly.

(b) The MAA first steps child care coordinator or designee:

(i) Approves the special needs request and signs and dates the first steps child care billing form (DSHS 14-316) in the appropriate section and returns the form to the authorizer; or

(ii) Informs the authorizer in writing if the request is denied and payment will not be made.

(7) MAA pays for authorized first steps child care when provided by any of the following, subject to the limitations and restrictions listed:

(a) A licensed child care home, center, facility, or foster home; and

(b) A friend, neighbor, or relative, other than those listed in subsection (8) of this section, who is unlicensed and:

(i) Has qualified based on a background check conducted prior to providing the child care (see subsection (9) of this section for information on the background check process);

(ii) Is eighteen years of age or older;

(iii) Has a valid Social Security number; and

(iv) Is authorized to work in the United States.

(8) The following individuals are not eligible to provide first steps child care:

(a) The spouse of the client.

(b) The partner of the client if the client and her partner share the same residence.

(c) The father of the pregnant client's unborn child(ren).

(d) The father of the client's other children(ren).

(e) A parent or stepparent of the client.

(f) A parent or stepparent of the client's spouse.

(g) A parent or stepparent of the client's partner if the client and her partner share the same residence.

(h) An older child(ren) of the:

(i) Client;

(ii) Client's spouse; or

(iii) Client's partner if the client and her partner share the same residence.

(i) An unlicensed child care provider:

(i) Whose background check is pending; or

(ii) Who was disqualified due to the background check.

(j) Any person under age eighteen.

(9) Each unlicensed individual child care provider who a client chooses to be a first steps child care provider is subject

to a background check under RCW 43.20A.710 and 74.15.-030. First steps child care will not be authorized by a first steps child care authorizer, or paid by MAA, until MAA's background check has been completed on the unlicensed child care provider. Each unlicensed first steps child care provider is subject to a new background check every two years from the date of the first background check.

(a) MAA's background check process includes all of the following:

(i) The unlicensed child care provider completes and signs the first steps child care background check form and gives it to the client. The client returns it to a first steps child care authorizer who submits it to BCCU. The child care provider's signature on the first steps child care background check form authorizes the department's BCCU to perform the background check.

(ii) BCCU performs a background check on the individual and notifies the appropriate first steps agency or CSO of the results. The first steps child care authorizer notifies both the client and child care provider of one of the following results:

(A) "No known record" (means the individual may provide first steps child care);

(B) "Disqualifying record" (means the individual may not provide first steps child care); or

(C) "Record" (means the individual has a criminal record that needs further review).

For cases needing further review, MAA:

(I) Follows the criteria described in this subsection to determine if the individual may or may not provide first steps child care; and

(II) Notifies the first steps agency or CSO, in writing, of the decision.

(b) The department's background check of unlicensed child care providers may include a review of:

(i) Records of criminal convictions and pending criminal charges as reported by the Washington state patrol (WSP);

(ii) Department findings of abuse, neglect, exploitation, and/or abandonment of children or vulnerable adults; and

(iii) Disciplinary board final decisions.

(c) The department's background check may include a review of law enforcement records of convictions and pending charges in other states or locations when the need for further information is indicated by:

(i) A person's prior residences;

(ii) Reports from credible community sources; or

(iii) An identification number indicating the subject has a record on file with the Federal Bureau of Investigation.

(d) For the purpose of conducting criminal history portions of background checks as required by chapters 43.20A and 74.15 RCW, the department:

(i) Considers only a person's convictions and pending charges; and

(ii) Does not solicit or use as the sole basis for disqualification, information about:

(A) Arrests not resulting in charges; and

(B) Dismissed charges.

(e) In certain situations, MAA may find an individual with conviction(s) to be eligible to provide child care to children through the first steps child care program if:

(i) A conviction for any crime listed in WAC 388-06-0180 occurred more than five years from the date of the first steps child care request; or

(ii) A conviction was for a crime other than those listed in WAC 388-06-0180; and

(iii) MAA uses the criteria in subsection (f) of this section and determines the individual qualifies to provide child care.

(f) When an individual's convictions for a crime meet the conditions in (e)(i) and (ii) of this subsection, MAA may review an individual's background to determine character, suitability and competence to have unsupervised access to children using the following factors:

(i) The amount of time that has passed since the finding or conviction;

(ii) The seriousness of the crime that led to the finding or conviction;

(iii) The number and types of other convictions in the individual's background;

(iv) The individual's age at the time of finding or conviction;

(v) Documentation indicating successful completion of all court-ordered programs and restitution;

(vi) The individual's behavior since the finding or conviction; and

(vii) The vulnerability of the children for whom care is needed.

(g) MAA considers findings or criminal charges that are pending to carry the same weight as a finding or conviction. The individual may provide proof to MAA that the charge has been dropped or there was an acquittal.

(h) MAA does not consider a crime a conviction if a pardon is granted or a court of law expunges or vacates the conviction.

(i) An MAA first steps child care program manager reviews all cases that are identified as "record," and reports the final decision to the first steps agency staff. The first steps agency staff notifies the client and the designated child care provider of the results.

(10) A client who does not agree with a department decision regarding first steps child care program services has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client or the department. After MAA 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.

(11) To be a client who is authorized to receive first steps child care for her child(ren) receives the following forms from a first steps child care authorizer and gives the forms to the child care provider:

(a) First steps child care billing form (DSHS 14-316);

(b) W-9 Form (request for taxpayer identification number and certification); and

(c) A first steps child care (MAA) background authorization form (DSHS 15-253) if the child care provider is unlicensed.

(12) To be paid for providing first steps child care, an authorized child care provider must, within ninety days of the first date the child care is provided:

(a) Complete, sign, and date the appropriate sections of the first steps child care billing form (DSHS 14-316);

(b) Complete an original W-9 Form (the W-9 is completed only once for MAA files unless the information changes); and

(c) Mail (or give) the original completed first steps child care billing form (DSHS 14-316) and W-9 Form (both forms must have the individual's original signature) to:

(i) The first steps authorizer, who submits them to MAA; or

(ii) The client and the client mails (or gives) the forms to the first steps authorizer, who submits them to MAA.

(13) MAA sets payment for first steps child care services at a maximum dollar amount per hour from legislatively appropriated funds. Payment is subject to any exceptions, restrictions, or other limitations listed in this section and other WAC. MAA pays the child care provider directly for first steps child care services when the client and the client's designated first steps child care provider meet all the criteria in this section.

[Statutory Authority: RCW 74.08.090, 74.09.800. 03-19-010, § 388-533-1000, filed 9/4/03, effective 10/5/03; 01-15-008, § 388-533-1000, filed 7/6/01, effective 8/6/01.]

Chapter 388-534 WAC

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

WAC

WAC 388-534-0100 EPSDT. (1) Persons who are eligible for medicaid are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 388-545-300, 388-545-500, and 388-545-700.

(c) Services not otherwise covered under the medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 CFR 441, Subpart B are met through a contract with transportation brokers throughout the state.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B. 02-07-016, § 388-534-0100, filed 3/8/02, effective 4/8/02. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-534-0100, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-534-0100, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-86-027, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 90-12-061 (Order 3019), § 388-86-027, filed 5/31/90, effective 7/1/90; 82-01-001 (Order 1725), § 388-86-027, filed 12/3/81; 81-10-015 (Order 1647), § 388-86-027, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-027, filed 10/9/80; 79-12-047 (Order 1457), § 388-86-027, filed 11/26/79; Order 1112, § 388-86-027, filed 4/15/76; Order 738, § 388-86-027, filed 11/22/72.]

WAC 388-534-0200 Enhanced payments for EPSDT screens for children receiving foster care placement services from the department of social and health services (DSHS). The medical assistance administration (MAA) reimburses providers an enhanced flat fee for EPSDT screens provided to children receiving certain foster care placement services from the department of social and health services (DSHS). See MAA's EPSDT billing instructions for specific billing code requirements and the fee.

(1) For the purposes of this section, foster care is defined as twenty-four hour per day, temporary, substitute care for a child:

(a) Placed away from the child's parents or guardians in licensed, paid, out-of-home care; and

(b) For whom the department or a licensed or certified child placing agency has placement and care responsibility.

(2) MAA pays an enhanced flat fee to the providers listed in subsection (3) of this section for EPSDT screens provided to only those children receiving foster care placement services from DSHS.

(3) The following providers are eligible to perform EPSDT screens and bill MAA the enhanced rate for children receiving foster care placement services from DSHS:

(a) EPSDT clinics;

(b) Physicians;

(c) Advanced registered nurse practitioners (ARNPs);

(d) Physician assistants (PAs) working under the guidance and MAA provider number of a physician;

(e) Nurses specially trained through the department of health (DOH) to perform EPSDT screens; and

(f) Registered nurses working under the guidance and MAA provider number of a physician or ARNP.

(4) In order to be paid an enhanced fee, services furnished by the providers listed in subsection (3) of this section must meet the federal requirements for EPSDT screens at 42 CFR Part 441 Subpart B, which were in effect as of December 1, 2001.

(5) The provider must retain documentation of the EPSDT screens in the client's medical file. The provider must use the DSHS Well Child Exam forms or provide equivalent information. DSHS Well Child Exam forms are available at no charge by sending a request in writing or by fax to:

DSHS Warehouse
P.O. Box 45816
Olympia, WA. 98504-5816
fax: 360-664-0597

(6) MAA conducts evaluations of client files and payments made under this program. MAA may recover the enhanced payment amount when:

(a) The client was not receiving foster care placement services from DSHS as defined in subsection (1) of this section when the EPSDT screen was provided; or

(b) Documentation was not in the client's medical file (see subsection (5) of this section).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B. 02-07-016, § 388-534-0200, filed 3/8/02, effective 4/8/02.]

Chapter 388-535 WAC
DENTAL-RELATED SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-535-1000 Dental-related services—Scope of coverage. [Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.] Repealed by 99-07-023, filed 3/10/99, effective 4/10/99. 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.

388-535-1010 Dental-related program introduction. [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, § 388-535-1010, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. 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.

388-535-1120 Coverage limits for dental-related services provided under state-only funded programs. [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, § 388-535-1120, filed 6/14/02, effective 7/15/02.] Repealed by 03-19-080, filed 9/12/03, effective 10/13/03. 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.

388-535-1150 Becoming a DSHS dental provider. [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, § 388-535-1150, 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), § 388-535-1150, filed 12/6/95, effective 1/6/96.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. 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.

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.

388-535-1250 Orthodontic coverage for DSHS children. [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, § 388-535-1250, 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), § 388-535-1250, filed 12/6/95, effective 1/6/96.] Repealed by 02-01-050, filed 12/11/01, effective 1/11/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225.

388-535-1260 Dental-related limits of state-only funded programs. [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, § 388-535-1260, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. 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.

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, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520.

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.

388-535-1300 Access to baby and child dentistry (ABCD) program. [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, § 388-535-1300, 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), § 388-535-1300, filed 12/6/95, effective 1/6/96.] Repealed by 02-11-136, filed 5/21/02, effective 6/21/02. 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. Later promulgation, see WAC 388-535-1245.

GENERAL

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 prac-

titioners. 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 nonmedicaid 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. 07-06-041, § 388-535-1050, 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 388-535-1060 Clients who are eligible for dental-related services. The following clients who receive services under the medical assistance programs listed in this section are eligible for covered dental-related services, subject to the restrictions and specific limitations described in this chapter and other applicable WAC:

(1) Children eligible for the:

(a) Categorically needy program (CN or CNP);

(b) Children's health insurance program (CNP-CHIP); and

(c) Limited casualty program - medically needy program (LCP-MNP).

(2) Adults eligible for the:

(a) Categorically needy program (CN or CNP); and

(b) Limited casualty program - medically needy program (LCP-MNP).

(3) Clients eligible for medical care services under the following state-funded only programs are eligible only for the limited dental-related services described in WAC 388-535-1065:

(a) General assistance - Unemployable (GA-U); and

(b) General assistance - Alcohol and Drug Abuse Treatment and Support Act (ADATSA) (GA-W).

(4) Clients who are enrolled in a managed care plan are eligible for medical assistance administration (MAA)-covered dental services that are not covered by their plan, under fee-for-service, subject to the provisions of chapter 388-535 WAC and other applicable WAC.

[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, § 388-535-1060, 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, § 388-535-1060, 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, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

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 388-535-1070 Dental-related services provider information. (1) The following providers are eligible to enroll with the medical assistance administration (MAA) to furnish and bill for dental-related services provided to eligible clients:

(a) Persons currently licensed by the state of Washington to:

(i) Practice dentistry or specialties of dentistry.

(ii) Practice as dental hygienists.

(iii) Practice as denturists.

(iv) Practice anesthesia by:

(A) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;

(B) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a certified registered nurse anesthetist (CRNA) under WAC 246-817-180; or

(C) Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the department of health (DOH) that is current at the time the billed service(s) is provided; or

(D) Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.

(v) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) Providing fluoride varnish under EPSDT.

(b) Facilities that are:

(i) Hospitals currently licensed by the DOH;

(ii) Federally qualified health centers (FQHCs);

(iii) Medicare-certified ambulatory surgical centers (ASCs);

(iv) Medicare-certified rural health clinics (RHCs); or

(v) Community health centers.

(c) Participating local health jurisdictions.

(d) Bordering city or out-of-state providers of dental-related services who are qualified in their states to provide these services.

(2) Subject to the restrictions and limitations in this section and other applicable WAC, MAA pays licensed providers participating in the MAA dental program for only those services that are within their scope of practice.

(3) For the dental specialty of oral and maxillofacial surgery:

(a) MAA requires a dentist to:

(i) Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and

(ii) Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

(A) The dentist must have participated at least three years in a maxillofacial residency program; and

(B) The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.

(b) A dental provider who meets the requirements in (3)(a) of this section must bill claims using appropriate current dental terminology (CDT) codes or current procedural terminology (CPT) codes for services that are identified as covered in WAC and MAA's published billing instructions or numbered memoranda.

(4) See WAC 388-502-0020 for provider documentation and record retention requirements. MAA requires additional dental documentation under specific sections in this chapter and as required by chapter 246-817 WAC.

(5) See WAC 388-502-0100 and 388-502-0150 for provider billing and payment requirements. Enrolled dental providers who do not meet the conditions in (3)(a) of this section must bill all claims using only the CDT codes for services that are identified in WAC and MAA's published billing instructions or numbered memoranda. MAA does not reimburse for billed CPT codes when the dental provider does not meet the requirements in subsection (3)(a) of this section.

(6) See WAC 388-502-0160 for regulations concerning charges billed to clients.

(7) See WAC 388-502-0230 for provider review and appeal.

(8) See WAC 388-502-0240 for provider audits and the audit appeal process.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520. 05-06-092, § 388-535-1070, filed 3/1/05, effective 4/1/05. 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, § 388-535-1070, 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, § 388-535-1070, filed 6/14/02, effective 7/15/02.]

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 preexisting 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 ionimer 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) 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.

(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 ser-

vice 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.

(iii) 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 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 seating date. An additional reline 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 alveoplasty 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, preexisting 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.]

ABCD DENTAL PROGRAM

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) The department pays enhanced fees only to ABCD-certified dentists and other department-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

(i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; and

(ii) Must include all of the following:

(A) "Lift the lip" training;

(B) Oral hygiene training;

(C) Risk assessment for early childhood caries;

(D) Dietary counseling;

(E) Discussion of fluoride supplements; and

(F) 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) Periodic oral evaluation, up to two visits per client, per calendar year, per provider or clinic;

(c) Topical application of fluoride varnish;

(d) Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in current department-published documents;

(e) Therapeutic pulpotomy;

(f) Prefabricated stainless steel crowns on primary teeth, as specified in current department-published documents;

(g) Resin-based composite crowns on anterior primary teeth; and

(h) Other dental-related services, as specified in current department-published documents.

(4) The client's file must show documentation of the ABCD program services provided.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-16-009, § 388-535-1245, filed 7/24/08, effective 8/24/08. 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.]

ADULTS' DENTAL-RELATED SERVICES

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 denturist, is limited to the initial examination appointment. The department does not cover an additional limited oral examination by a denturist 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 development 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 substitution 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 depart-

ment 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.

(iii) 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;

(iii) 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 reevaluations;

(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, eposteal implant, and transosteal implant), abutments or implant sup-

ported 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.]

PAYMENT

WAC 388-535-1350 Payment methodology for dental-related services. The medical assistance administration (MAA) uses the description of dental services described in the American Dental Association's Current Dental Terminology, and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, MAA pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the excep-

tions and restrictions listed under WAC 388-535-1100 and 388-535-1400.

(2) MAA sets maximum allowable fees for dental services provided to children as follows:

(a) MAA's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) MAA consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) MAA consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) MAA reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(5) MAA pays eligible providers listed in WAC 388-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

(6) Dental hygienists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for providing dentures and partials.

(8) MAA makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) MAA may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(10) MAA does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in MAA's reimbursement for comprehensive oral evaluations or limited oral evaluations.

[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, § 388-535-1350, 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, § 388-535-1350, 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, § 388-535-1350, 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), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1400 Payment for dental-related services. (1) The medical assistance administration (MAA) considers that a provider who furnishes covered dental services to an eligible client has accepted MAA's rules and fees.

(2) Participating providers must bill MAA their usual and customary fees.

(3) Payment for dental services is based on MAA's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) MAA pays the provider the lesser of the billed charge (usual and customary fee) or MAA's maximum allowable fee.

(5) MAA pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) Participating providers must bill a client according to WAC 388-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 388-535-1240 and 388-535-1290.

[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, § 388-535-1400, 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, § 388-535-1400, 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, § 388-535-1400, 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), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1450 Payment for denture laboratory services. The medical assistance administration (MAA) does not directly reimburse denture laboratories. MAA's reimbursement for complete dentures, immediate dentures, partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

[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, § 388-535-1450, 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, § 388-535-1450, 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, § 388-535-1450, 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), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1500 Payment for dental-related hospital services. The medical assistance administration (MAA) pays for medically necessary dental-related hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[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, § 388-535-1500, 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, § 388-535-1500, 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), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1550 Payment for dental care provided out-of-state. See WAC 388-501-0180, 388-501-0182, and 388-501-0184 for services provided outside the state of Washington. See WAC 388-501-0175 for designated bordering cities.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-535-1550, filed 3/31/08, effective 5/1/08. 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, § 388-535-1550, 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, § 388-535-1550, 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), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

Chapter 388-535A WAC
ORTHODONTIC SERVICES

WAC

WAC 388-535A-0010 Definitions for orthodontic services. The following definitions and those found in WAC 388-500-0005 apply to this chapter.

"Appliance placement" means the application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

"Cleft" means an opening or fissure involving the dentition and supporting structures, especially one occurring in utero. These can be:

(1) Cleft lip;

(2) Cleft palate (involving the roof of the mouth); or

(3) Facial clefts (e.g., macrostomia).

"Comprehensive full orthodontic treatment" means utilizing fixed orthodontic appliances for treatment of the permanent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

"Craniofacial team" means a cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated management, promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

"Dental dysplasia" means an abnormality in the development of the teeth.

"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.

"Hemifacial microsomia" means a developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face appears smaller sized).

"Interceptive orthodontic treatment" means procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

"Limited transitional orthodontic treatment" means orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

"Malocclusion" means improper alignment of biting or chewing surfaces of upper and lower teeth.

"Maxillofacial" means relating to the jaws and face.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Orthodontics" means treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Orthodontist" means a dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the department of health.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0010, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0010, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0010, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0020 Clients who are eligible for orthodontic treatment and orthodontic services. (1) Subject to the limitations of this chapter and the age restrictions listed in this section, the department covers medically necessary orthodontic treatment and orthodontic-related services

for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate, as follows:

(a) Clients in the categorically needy program (CNP) and the medically needy program (MNP) may receive orthodontic treatment and orthodontic-related services through age twenty. Any orthodontic treatment plan that extends beyond the client's twenty-first birthday will not be approved by the department.

(b) Clients in the state children's health insurance program (CHIP) may receive orthodontic treatment and orthodontic-related services through age eighteen.

(c) Clients who are eligible for services under the EPSDT program may receive orthodontic treatment and orthodontic-related services under the provisions of WAC 388-534-0100.

(2) Eligible clients may receive the same orthodontic treatment and orthodontic-related services in recognized out-of-state bordering cities on the same basis as if provided in-state. See WAC 388-501-0175.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0020, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0020, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0020, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0030 Providers of orthodontic treatment and orthodontic-related services. The following provider types may furnish and be paid for providing covered orthodontic treatment and orthodontic-related services to eligible medical assistance clients:

(1) Orthodontists;

(2) Pediatric dentists;

(3) General dentists; and

(4) Department recognized craniofacial teams or other orthodontic specialists approved by the department.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0030, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0030, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0030, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0040 Covered and noncovered orthodontic treatment and orthodontic-related services and limitations to coverage. (1) Subject to the limitations in this section and other applicable WAC, the department covers orthodontic treatment and orthodontic-related services for a client who has one of the medical conditions listed in (a) and (b) of this subsection. Treatment and follow-up care must be performed only by an orthodontist or department-recognized craniofacial team and do not require prior authorization.

(a) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement.

(b) The following craniofacial anomalies:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dental dysplasia;

(D) Arthrogryposis; or

(E) Marfan syndrome.

(2) Subject to prior authorization requirements and the limitations in this section and other applicable WAC, the department covers orthodontic treatment and orthodontic-related services for severe malocclusions with a Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score of twenty-five or higher.

(3) The department may cover orthodontic treatment for dental malocclusions other than those listed in subsection (1) and (2) of this section on a case-by-case basis and when prior authorized.

(4) The department does not cover the following orthodontic treatment or orthodontic-related services:

(a) Replacement of lost or repair of broken orthodontic appliances;

(b) Orthodontic treatment for cosmetic purposes;

(c) Orthodontic treatment that is not medically necessary (see WAC 388-500-0005);

(d) Out-of-state orthodontic treatment, except as stated in WAC 388-501-0180 (see also WAC 388-501-0175 for medical care provided in bordering cities); or

(e) Orthodontic treatment and orthodontic-related services that do not meet the requirements of this section or other applicable WAC.

(5) The department covers the following orthodontic treatment and orthodontic-related services, subject to the limitations listed (providers must bill for these services according to WAC 388-535A-0060):

(a) Panoramic radiographs (X rays) when medically necessary.

(b) Interceptive orthodontic treatment, once per a client's lifetime.

(c) Limited transitional orthodontic treatment, once per a client's lifetime. The treatment must be completed within twelve months of the date of the original appliance placement (see subsection (6)(a) of this section for information on limitation extensions).

(d) Comprehensive full orthodontic treatment once per a client's lifetime. The treatment must be completed within thirty months of the date of the original appliance placement (see subsection (6)(a) of this section for information on limitation extensions).

(e) Orthodontic appliance removal only when:

(i) The client's appliance was placed by a different provider or dental clinic; and

(ii) The provider has not furnished any other orthodontic treatment or orthodontic-related services to the client.

(f) Other medically necessary orthodontic treatment and orthodontic-related services as determined by the department.

(6) The department evaluates a request for orthodontic treatment or orthodontic-related services:

(a) That are in excess of the limitations or restrictions listed in this section, according to WAC 388-501-0169; and

(b) That are listed as noncovered according to WAC 388-501-0160.

(7) The department reviews requests for orthodontic treatment or orthodontic-related services for clients who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0040, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-535A-0040, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520

and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0040, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0040, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0050 Authorization and prior authorization for orthodontic treatment and orthodontic-related services. (1) When the department authorizes an interceptive orthodontic treatment, limited orthodontic treatment, full orthodontic treatment, or orthodontic-related services for a client, including a client eligible for services under the EPSDT program, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided.

(2) For orthodontic treatment of a client with cleft lip, cleft palate, or other craniofacial anomaly, prior authorization is not required if the client is being treated by a department-recognized craniofacial team, or an orthodontic specialist who has been approved by the department to treat cleft lip, cleft palate, or other craniofacial anomalies.

(3) Subject to the conditions and limitations of this section and other applicable WAC, the department requires prior authorization for orthodontic treatment and/or orthodontic-related services for other dental malocclusions that are not listed in WAC 388-535A-0040(1).

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0050, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0050, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0060 Payment for orthodontic treatment and orthodontic-related services. (1) The department pays providers for furnishing covered orthodontic treatment and orthodontic-related services described in WAC 388-535A-0040 according to this section and other applicable WAC.

(2) The department considers that a provider who furnishes covered orthodontic treatment and orthodontic-related services to an eligible client has accepted the department's fees as published in the department's fee schedules.

(3) **Interceptive orthodontic treatment.** The department pays for interceptive orthodontic treatment as follows:

(a) The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months.

(b) Treatment must be completed within twelve months of the date of appliance placement.

(4) **Limited transitional orthodontic treatment.** The department pays for limited transitional orthodontic treatment as follows:

(a) The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months. The provider must bill the department with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval during the treatment.

(c) Treatment must be completed within twelve months of the date of appliance placement. Treatment provided after one year from the date the appliance is placed requires a limitation extension. See WAC 388-535A-0040(6).

(5) **Comprehensive full orthodontic treatment.** The department pays for comprehensive full orthodontic treatment as follows:

(a) The first six months of treatment starts the date the initial appliance is placed and includes active treatment for the first six months. The provider must bill the department with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement.

(c) Treatment must be completed with thirty months of the date of appliance placement. Treatment provided after thirty months from the date the appliance is placed requires a limitation extension. See WAC 388-535A-0040(6).

(6) Payment for orthodontic treatment and orthodontic-related services is based on the department's published fee schedule.

(7) Orthodontic providers who are in department-designated bordering cities must:

(a) Meet the licensure requirements of their state; and

(b) Meet the same criteria for payment as in-state providers, including the requirements to contract with the department.

(8) If the client's eligibility for orthodontic treatment under WAC 388-535A-0020 ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility. The department does not pay for these services.

(9) The client is responsible for payment of any orthodontic service or treatment received during any period of ineligibility, even if the treatment was started when the client was eligible. The department does not pay for these services.

(10) See WAC 388-502-0160 and 388-501-0200 for when a provider or a client is responsible to pay for a covered service.

[Statutory Authority: RCW 74.04.050, 74.08.090. 08-17-009, § 388-535A-0060, filed 8/7/08, effective 9/7/08. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0060, filed 12/11/01, effective 1/11/02.]

Chapter 388-537 WAC
SCHOOL SERVICES

WAC

WAC 388-537-0100 School medical services for students in special education programs. (1) The medical assistance administration (MAA) pays school districts or educational service districts (ESD) for qualifying medical services provided to an eligible student. To be covered under this section, the student must be eligible for Title XIX (i.e., either the categorically needy or medically needy programs).

(2) To qualify for payment under this section, the medical services must be provided:

(a) By the school district or the ESD; and

(b) To the eligible special education student as part of the student's individualized education program (IEP) or individualized family service plan (IFSP).

(3) To qualify for payment under this section, the medical services must be provided by one of the following service providers:

(a) A qualified medicaid provider as described under WAC 388-502-0010;

(b) A psychologist, licensed by the state of Washington or granted an educational staff associate (ESA) certificate by the state board of education;

(c) A school guidance counselor, or a school social worker, who has been granted an ESA certificate by the state board of education; or

(d) A person trained and supervised by any of the following:

(i) A licensed registered nurse;

(ii) A licensed physical therapist or physiatrist;

(iii) A licensed occupational therapist; or

(iv) A speech pathologist or audiologist who:

(A) Has been granted a certificate of clinical competence by the American speech, hearing, and language association;

(B) Is a person who completed the equivalent educational and work experience necessary for such a certificate; or

(C) Is a person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) Student service recommendations and referrals must be updated at least annually.

(5) The student does not need a provider prescription to receive services described under this section.

(6) MAA pays for school-based medical services according to the department-established rate or the billed amount, whichever is lower.

(7) MAA does not pay individual school practitioners who provide school-based medical services.

(8) For medical services billed to medicaid, school districts or ESD, must pursue third-party resources.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-537-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-537-0100, filed 12/14/99, effective 1/14/00.]

Chapter 388-538 WAC
MANAGED CARE

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-538-001 Purpose. [Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-001, filed 8/11/93, effective 9/11/93. Formerly WAC 388-83-010 (part).] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

388-538-066 Children's health insurance program (CHIP) enrollees. [Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-066, filed 2/1/00, effective 3/3/00.] Repealed by 02-01-075, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396.

388-538-080 Managed care exemptions. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-080, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-080, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 96-24-074, § 388-538-080, filed 12/2/96, effective 1/1/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-080, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-080, filed 8/11/93, effective 9/11/93.] Repealed by 03-18-109, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.08.090, 74.09.522.

388-538-090 Client's choice of primary care provider. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-090, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-090, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

388-538-150 Managed care medical audit. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-150, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

WAC 388-538-050 Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. References to managed care in this chapter do not apply to mental health managed care administered under chapter 388-865 WAC.

"Action" means one or more of the following:

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service;

(4) The failure to provide services in a timely manner, as defined by the state; or

(5) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. 438.408(b).

"Ancillary health services" means healthcare services that are auxiliary, accessory, or secondary to a primary healthcare service.

"Appeal" means a request by an enrollee or provider with written permission of an enrollee for reconsideration of an action.

"Assign" or **"assignment"** means the department selects an MCO or primary care case management (PCCM) provider to serve a client who has not selected an MCO or PCCM provider.

"Auto enrollment" means the department has automatically enrolled a client into an MCO in the client's area of residence.

"Basic health" or **"BH"** means the healthcare program authorized by chapter 70.47 RCW and administered by the health care authority (HCA).

"Basic health plus"—Refer to WAC 388-538-065.

"Children with special healthcare needs" means children younger than age nineteen who are identified by the department as having special healthcare needs. This includes:

(1) Children designated as having special healthcare needs by the department of health (DOH) and receiving services under the Title V program;

(2) Children eligible for Supplemental Security Income under Title XVI of the Social Security Act (SSA); and

(3) Children who are in foster care or who are served under subsidized adoption.

"Client" means, for the purposes of this chapter, an individual eligible for any medical assistance program, including managed care programs, but who is not enrolled with an MCO or PCCM provider. In this chapter, "client" refers to a person before he or she is enrolled in managed care, while "enrollee" refers to an individual eligible for any medical assistance program who is enrolled in managed care.

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

"Disenrollment"—See "end enrollment."

"Emergency medical condition" means a condition meeting the definition in 42 C.F.R. 438.114(a).

"Emergency services" means services defined in 42 C.F.R. 438.114(a).

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 388-538-130.

"Enrollee" means an individual eligible for any medical assistance program enrolled in managed care with an MCO or PCCM provider that has a contract with the state.

"Enrollee's representative" means an individual with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs" means enrollees having chronic and disabling conditions and the conditions:

(1) Have a biologic, psychologic, or cognitive basis;

(2) Have lasted or are virtually certain to last for at least one year; and

(3) Produce one or more of the following conditions stemming from a disease:

(a) Significant limitation in areas of physical, cognitive, or emotional function;

(b) Dependency on medical or assistive devices to minimize limitation of function or activities; or

(c) In addition, for children, any of the following:

(i) Significant limitation in social growth or developmental function;

(ii) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

(iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means department approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Grievance system" means the overall system that includes grievances and appeals handled at the MCO level and access to the department's hearing process.

"Healthcare service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Healthy Options program" or **"HO program"** means the department's prepaid managed care health program for medicaid-eligible clients and clients enrolled in the state children's health insurance program (SCHIP).

"Managed care" means a comprehensive healthcare delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract" means the agreement between the department and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the department under a comprehensive risk contract to provide prepaid healthcare services to eligible clients under the department's managed care programs.

"Mandatory enrollment" means the department's requirement that a client enroll in managed care.

"Mandatory service area" means a service area in which eligible clients are required to enroll in an MCO.

"Nonparticipating provider" means a healthcare provider that does not have a written agreement with an MCO but that provides MCO-contracted healthcare services to managed care enrollees with the MCO's authorization.

"Participating provider" means a healthcare provider with a written agreement with an MCO to provide healthcare services to the MCO's managed care enrollees. A participating provider must look solely to the MCO for payment for such services.

"Primary care case management" or **"PCCM"** means the healthcare management activities of a provider that contracts with the department to provide primary healthcare ser-

vices and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or **"PCP"** means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Prior authorization" or **"PA"** means a process by which enrollees or providers must request and receive department approval for services provided through the department's fee-for-service system, or MCO approval for services provided through the MCO, for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement.

"Timely" means in relation to the provision of services, an enrollee has the right to receive medically necessary healthcare as expeditiously as the enrollee's health condition requires. In relation to authorization of services and grievances and appeals, "timely" means according to the department's managed care program contracts and the time frames stated in this chapter.

"Washington medicaid integration partnership" or **"WMIP"** means the managed care program that is designed to integrate medical, mental health, chemical dependency treatment, and long-term care services into a single coordinated health plan for eligible aged, blind, or disabled clients.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-050, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-050, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-050, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-050, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]

WAC 388-538-060 Managed care and choice. (1) Except as provided in subsection (2) of this section, the department requires a client to enroll in managed care when that client:

(a) Is eligible for one of the medical assistance programs for which enrollment is mandatory;

(b) Resides in an area where enrollment is mandatory; and

(c) Is not exempt from managed care enrollment or the department has not ended the client's managed care enrollment, consistent with WAC 388-538-130, and any related hearing has been held and decided.

(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants may choose one of the following:

(a) Enrollment with a managed care organization (MCO) available in their area;

(b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or

(c) The department's fee-for-service system.

(3) To enroll with an MCO or PCCM provider, a client may:

(a) Call the department's toll-free enrollment line at 800-562-3022;

(b) Mail a postage-paid completed managed care enrollment form (healthy options sign-up form, DSHS 13-664) to the department's unit responsible for managed care enrollment; or

(c) Fax the managed care enrollment form (healthy options sign-up form, DSHS 13-664) to the department at 360-725-2144.

(4) A client must enroll with an MCO provider available in the area where the client resides.

(5) All family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 388-501-0135 must enroll with the same MCO but may enroll in a different MCO than the family member placed in the PRC program.

(6) When a client requests enrollment with an MCO or PCCM provider, the department enrolls a client effective the earliest possible date given the requirements of the department's enrollment system. The department does not enroll clients retrospectively.

(7) The department assigns a client who does not choose an MCO or PCCM provider as follows:

(a) If the client has a family member or family members enrolled with an MCO, the client is enrolled with that MCO;

(b) If the client does not have a family member or family members enrolled with an MCO that is currently under contract with the department, and the client was previously enrolled with the MCO or PCCM provider, and the department can identify the previous enrollment, the client is reenrolled with the same MCO or PCCM provider;

(c) If the client cannot be assigned according to (a) or (b) of this subsection, the department assigns the client as follows:

(i) If an AI/AN client does not choose an MCO or PCCM provider, the department assigns the client to a tribal PCCM provider if that client resides in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by the department's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.

(ii) If a non-AI/AN client does not choose an MCO provider, the department assigns the client to an MCO available in the area where the client resides. The MCO is responsible for primary care provider (PCP) choice and assignment.

(iii) For clients who are new recipients or who have had a break in eligibility of greater than two months, the department sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The assigned client has ten calendar days to contact the department to change the MCO or PCCM provider assignment before enrollment is effective. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which

the client must respond in order to change the assignment, and the toll-free telephone number of either:

(A) The MCO (for enrollees assigned to an MCO); or

(B) The department (for enrollees assigned to a PCCM provider).

(iv) If the client has a break in eligibility of less than two months, the client will be automatically reenrolled with his or her previous MCO or PCCM provider and no notice will be sent.

(8) The department:

(a) Helps facilitate the choice of a PCP by providing information regarding available providers contracted with the MCOs in the client's service area; and

(b) Upon request, will assist clients in identifying an MCO with which their provider participates.

(9) An MCO enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An MCO enrollee may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) A different PCP or clinic participating with the enrollee's MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in the relevant managed care contract if the enrollee does not choose a PCP or clinic.

(c) An MCO enrollee may change PCPs or clinics in an MCO for any reason, with the change becoming effective no later than the beginning of the month following the enrollee's request.

(d) An MCO enrollee may file a grievance with the MCO if the MCO does not approve an enrollee's request to change PCPs or clinics.

(e) MCO enrollees required to participate in the department's PRC program may be limited in their right to change PCPs (see WAC 388-501-0135).

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-060, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-060, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-060, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-060, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-060, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

WAC 388-538-061 Voluntary enrollment into managed care—Washington medicaid integration partnership (WMIP). (1) The purpose of this section is to describe the managed care requirements for clients eligible for the Washington Medicaid Integration Partnership (WMIP).

(2) Unless otherwise stated in this section, all of the provisions of chapter 388-538 WAC apply to clients enrolled in WMIP.

(3) The following sections of chapter 388-538 WAC do not apply to WMIP enrollees:

(a) WAC 388-538-060. However, WAC 388-538-060(9), describing enrollees' ability to choose their PCP, does apply to WMIP enrollees;

(b) WAC 388-538-063;

(c) WAC 388-538-065;

(d) WAC 388-538-068; and

(e) WAC 388-538-130. However, WAC 388-538-130 (3) and (4), describing the process used when the department receives a request from an MCO to remove an enrollee from enrollment in managed care, do apply to WMIP enrollees. Also, WAC 388-538-130(9), describing the MCO's ability to refer enrollees to the department's "Patient Review and Coordination" program, does apply to WMIP enrollees.

(4) The process for enrollment of WMIP clients is as follows:

(a) Enrollment in WMIP is voluntary, subject to program limitations in (b) and (d) of this subsection.

(b) For WMIP, the department automatically enrolls clients, with the exception of American Indian/Alaska natives and clients eligible for both medicare and medicaid, when they:

(i) Are aged, blind, or disabled;

(ii) Are twenty-one years of age or older; and

(iii) Receive categorically needy medical assistance.

(c) American Indian/Alaska native (AI/AN) clients and clients who are eligible for both medicare and medicaid who meet the eligibility criteria in (b) of this subsection may voluntarily enroll or end enrollment in WMIP at any time.

(d) The department will not enroll a client in WMIP, or will end an enrollee's enrollment in WMIP when the client has, or becomes eligible for, CHAMPUS/TRICARE or any other third-party healthcare coverage that would:

(i) Require the department to either exempt the client from enrollment in managed care; or

(ii) End the enrollee's enrollment in managed care.

(e) A client or enrollee in WMIP, or the client's or enrollee's representative, may end enrollment from the MCO at any time without cause. The client may then reenroll at any time with the MCO. The department ends enrollment for clients prospectively to the first day of the month following the request to end enrollment, except as provided in (f) of this subsection.

(f) A client or enrollee may request that the department retroactively end enrollment from WMIP. On a case-by-case basis, the department may retroactively end enrollment from WMIP when, in the department's judgment:

(i) The client or enrollee has a documented and verifiable medical condition; and

(ii) Enrollment in managed care could cause an interruption of on-going treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(5) In addition to the scope of medical care services described in WAC 388-538-095, WMIP includes mental health, chemical dependency treatment, and long-term care services.

(6) The department sends each client written information about covered services when the client is eligible to enroll in WMIP, and any time there is a change in covered services. In addition, the department requires MCOs to provide new enrollees with written information about covered services.

This notice informs the client about the right to end enrollment and how to do so.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-061, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-061, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-061, filed 12/8/04, effective 1/8/05.]

WAC 388-538-063 GAU clients residing in a designated mandatory managed care plan county. (1) In Laws of 2007, chapter 522, section 209 (13) and (14), the legislature authorized the department to provide coverage of certain medical and mental health benefits to clients who:

(a) Receive medical care services (MCS) under the general assistance unemployable (GAU) program; and

(b) Reside in a county designated by the department as a mandatory managed care plan county.

(2) The only sections of chapter 388-538 WAC that apply to GAU clients described in this section are incorporated by reference into this section.

(3) GAU clients who reside in a county designated by the department as a mandatory managed care plan county must enroll in a managed care plan as required by WAC 388-505-0110(7) to receive department-paid medical care. A GAU client enrolled in an MCO plan under this section is defined as a GAU enrollee.

(4) GAU clients are exempt from mandatory enrollment in managed care if they are American Indian or Alaska Native (AI/AN) and meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) The department exempts a GAU client from mandatory enrollment in managed care:

(a) If the GAU client resides in a county that is not designated by the department as a mandatory MCO plan county; or

(b) In accordance with WAC 388-538-130(3).

(6) The department ends a GAU enrollee's enrollment in managed care in accordance with WAC 388-538-130(4).

(7) On a case-by-case basis, the department may grant a GAU client's request for exemption from managed care or a GAU enrollee's request to end enrollment when, in the department's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) The department enrolls GAU clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The department does not enroll clients in managed care on a retroactive basis.

(9) Managed care organizations (MCOs) that contract with the department to provide services to GAU clients must meet the qualifications and requirements in WAC 388-538-067 and 388-538-095 (3)(a), (b), (c), and (d).

(10) The department pays MCOs capitated premiums for GAU enrollees based on legislative allocations for the GAU program.

(11) GAU enrollees are eligible for the scope of care as described in WAC 388-501-0060 for medical care services (MCS) programs.

(a) A GAU enrollee is entitled to timely access to medically necessary services as defined in WAC 388-500-0005;

(b) MCOs cover the services included in the managed care contract for GAU enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for GAU enrollees;

(c) The department pays providers on a fee-for-service basis for the medically necessary, covered medical care services not covered under the MCO's contract for GAU enrollees;

(d) A GAU enrollee may obtain:

(i) Emergency services in accordance with WAC 388-538-100; and

(ii) Mental health services in accordance with this section.

(12) The department does not pay providers on a fee-for-service basis for services covered under the MCO's contract for GAU enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted healthcare services that are:

(a) Provided by an MCO-contracted provider; or

(b) Authorized by the MCO and provided by nonparticipating providers.

(13) The following services are not covered for GAU enrollees unless the MCO chooses to cover these services at no additional cost to the department:

(a) Services that are not medically necessary;

(b) Services not included in the medical care services scope of care, unless otherwise specified in this section;

(c) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(14) A provider may bill a GAU enrollee for noncovered services described in subsection (12) of this section, if the requirements of WAC 388-502-0160 and 388-538-095(5) are met.

(15) Mental health services and care coordination are available to GAU enrollees on a limited basis, subject to available funding from the legislature and an appropriate delivery system.

(16) A care coordinator (a person employed by the MCO or one of the MCO's subcontractors) provides care coordination to a GAU enrollee in order to improve access to mental health services. Care coordination may include brief, evidenced-based mental health services.

(17) To ensure a GAU enrollee receives appropriate mental health services and care coordination, the department requires the enrollee to complete at least one of the following assessments:

(a) A physical evaluation;

(b) A psychological evaluation;

(c) A mental health assessment completed through the client's local community mental health agency (CMHA) and/or other mental health agencies;

(d) A brief evaluation completed through the appropriate care coordinator located at a participating community health center (CHC);

(e) An evaluation by the client's primary care provider (PCP); or

(f) An evaluation completed by medical staff during an emergency room visit.

(18) A GAU enrollee who is screened positive for a mental health condition after completing one or more of the assessments described in subsection (17) of this section may receive one of the following levels of care:

(a) **Level 1.** Care provided by a care coordinator when it is determined that the GAU enrollee does not require Level 2 services. The care coordinator will provide the following, as determined appropriate and available:

(i) Evidenced-based behavioral health services and care coordination to facilitate receipt of other needed services.

(ii) Coordination with the PCP to provide medication management.

(iii) Referrals to other services as needed.

(iv) Coordination with consulting psychiatrist as necessary.

(b) **Level 2.** Care provided by a contracted provider when it is determined that the GAU enrollee requires services beyond Level 1 services. A care coordinator refers the GAU enrollee to the appropriate provider for services:

(i) A regional support network (RSN) contracted provider; or

(ii) A contractor-designated entity.

(19) Billing and reporting requirements and payment amounts for mental health services and care coordination provided to GAU enrollees are described in the contract between the MCO and the department.

(20) The total amount the department pays in any biennium for services provided pursuant to this section 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 appropriation.

(21) Nothing in this section shall be construed as creating a legal entitlement to any GAU client for the receipt of any medical or mental health service by or through the department.

(22) An MCO may refer enrollees to the department's patient review and coordination (PRC) program according to WAC 388-501-0135.

(23) The grievance and appeal process found in WAC 388-538-110 applies to GAU enrollees described in this section.

(24) The hearing process found in chapter 388-02 WAC and WAC 388-538-112 applies to GAU enrollees described in this section.

[Statutory Authority: RCW 74.08.090 and 2007 c 522 § 209 (13)-(14). 08-10-048, § 388-538-063, filed 5/1/08, effective 6/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-538-063, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-063, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). 04-15-003, § 388-538-063, filed 7/7/04, effective 8/7/04.]

WAC 388-538-065 Medicaid-eligible basic health (BH) enrollees. (1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for medicaid under pediatric and maternity expansion provisions of the Social Security Act. The department determines medicaid eligibility for children and pregnant women who enroll through BH.

(2) Eligible children are enrolled in the basic health plus program and eligible pregnant women are enrolled in the maternity benefits program.

(3) The administrative rules and regulations that apply to managed care enrollees also apply to medicaid-eligible clients enrolled through BH, except as follows:

(a) The process for enrolling in managed care described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers BH;

(b) American Indian/Alaska native (AI/AN) clients cannot choose fee-for-service or PCCM as described in WAC 388-538-060(2). They must enroll in a BH-contracted MCO.

(c) If a medicaid eligible client applying for BH plus does not choose an MCO prior to the department's eligibility determination, the client is transferred from BH plus to the department for assignment to managed care.

(d) The department does not consider the basic health plus and the maternity benefits programs to be third party.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-065, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.-090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-065, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-065, filed 2/1/00, effective 3/3/00.]

WAC 388-538-067 Managed care provided through managed care organizations (MCOs). (1) Managed care organizations (MCOs) may contract with the department to provide prepaid healthcare services to eligible clients. The MCOs must meet the qualifications in this section to be eligible to contract with the department. The MCO must:

(a) Have a certificate of registration from the office of the insurance commissioner (OIC) that allows the MCO to provide the healthcare services;

(b) Accept the terms and conditions of the department's managed care contract;

(c) Be able to meet the network and quality standards established by the department; and

(d) Accept the prepaid rates published by the department.

(2) The department reserves the right not to contract with any otherwise qualified MCO.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-067, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-067, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-067, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-112, § 388-538-067, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450,

1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

WAC 388-538-068 Managed care provided through primary care case management (PCCM). A provider may contract with the department as a primary care case management (PCCM) provider to coordinate healthcare services to eligible clients under the department's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:

(1) Have a core provider agreement with the department;

(2) Be a recognized urban Indian health center or tribal clinic;

(3) Accept the terms and conditions of the department's PCCM contract;

(4) Be able to meet the quality standards established by the department; and

(5) Accept PCCM rates published by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-068, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-068, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 388-538-070 Managed care payment. (1) The department pays managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been developed in accordance with generally accepted actuarial principles and practices;

(b) Are appropriate for the populations to be covered and the services to be furnished under the MCO contract;

(c) Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;

(d) Are based on historical analysis of financial cost and/or rate information; and

(e) Are paid based on legislative allocations.

(2) The department pays primary care case management (PCCM) providers a monthly case management fee according to contracted terms and conditions.

(3) The department does not pay providers under the fee-for-service system for a service that is the MCO's responsibility, even if the MCO has not paid for the service for any reason. The MCO is solely responsible for payment of MCO-contracted healthcare services.

(4) The department pays an enhancement rate to federally qualified healthcare centers (FQHC) and rural health clinics (RHC) for each client enrolled with MCOs through the FQHC or RHC. The enhancement rate from the department is in addition to the negotiated payments FQHCs and RHCs receive from the MCOs for services provided to MCO enrollees.

(5) The department pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child(ren) and the MCO pays for any part of labor and delivery.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-070, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-070, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-070, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-070, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

WAC 388-538-095 Scope of care for managed care enrollees. (1) Managed care enrollees are eligible for the scope of medical care services as described in WAC 388-501-0060 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the MCO contract for MCO enrollees. MCOs may, at their discretion, cover additional services not required under the MCO contract. However, the department may not require the MCO to cover any additional services outside the scope of services negotiated in the MCO's contract with the department.

(c) The department covers medically necessary services described in WAC 388-501-0060 and 388-501-0065 that are excluded from coverage in the MCO contract.

(d) The department covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee, or refer the enrollee to other providers who are contracted with the department for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. Services that require PCCM provider referral are described in the PCCM contract. The department informs an enrollee about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain specific services described in the managed care contract from either an MCO provider or from a provider with a separate agreement with the department without needing to obtain a referral from the PCP or MCO. These services are communicated to enrollees by the department and MCOs as described in (f) of this subsection.

(f) The department sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by the department, and which services are covered by MCOs. In addition, the department requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by the department through PCCM contracts for managed care:

(a) The department covers medically necessary services included in the categorically needy scope of care and rendered by providers who have a current core provider agreement with the department to provide the requested service;

(b) The department may require the PCCM provider to obtain authorization from the department for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a hearing for review of PCCM provider or the department coverage decisions (see WAC 388-538-110); and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from the department.

(3) For services covered by the department through contracts with MCOs:

(a) The department requires the MCO to subcontract with a sufficient number of providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) The department requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(e) The department requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(f) A managed care enrollee does not need a PCP referral to receive women's healthcare services, as described in RCW 48.42.100, from any women's healthcare provider participating with the MCO. Any covered services ordered and/or prescribed by the women's healthcare provider must meet the MCO's service authorization requirements for the specific service.

(g) For enrollees temporarily outside their MCO services area, the MCO is required to cover enrollees for up to ninety days for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.

(4) Unless the MCO chooses to cover these services, or an appeal, independent review, or a hearing decision reverses an MCO or department denial, the following services are not covered:

(a) For all managed care enrollees:

(i) Services that are not medically necessary[.]

(ii) Services not included in the categorically needy scope of services.

(iii) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions.

(b) For MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO.

(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the requirements of WAC 388-502-0160 are met.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-095, filed 7/18/08, effective 8/18/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-538-095, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-095, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-095, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-095, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-095, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

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 388-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services, for emergency medical conditions from any qualified medicaid provider. ("Emergency services" and "emergency medical condition" are defined in WAC 388-538-050.)

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) The department covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or the department.

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish medicaid services, without regard to whether the provider is a participating or nonparticipating provider.

(4) An enrollee who requests emergency services is entitled to receive an exam to determine if the enrollee has an emergency medical condition. What constitutes an emergency medical condition may not be limited on the basis of diagnosis or symptoms.

(5) The MCO must cover emergency services provided to an enrollee when:

(a) The enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition; and

(b) The plan provider or other MCO representative instructs the enrollee to seek emergency services.

(6) In any disagreement between a hospital and the MCO about whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails.

(7) Under 42 C.F.R. 438.114, the enrollee's MCO must cover and pay for:

(a) Emergency services provided to enrollees by an emergency room provider, hospital or fiscal agent outside the managed care system; and

(b) Any screening and treatment the enrollee requires subsequent to the provision of the emergency services.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-100, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-100, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-100, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-100, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-100, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

WAC 388-538-110 The grievance system for managed care organizations (MCO). (1) This section contains information about the grievance system for managed care organization (MCO) enrollees, which includes grievances and appeals. See WAC 388-538-111 for information about the grievance system for PCCM enrollees, which includes grievances and appeals.

(2) An MCO enrollee may voice a grievance or appeal an action by an MCO to the MCO either orally or in writing.

(3) MCOs must maintain records of grievances and appeals and must review the information as part of the MCO's quality strategy.

(4) MCOs must provide information describing the MCO's grievance system to all providers and subcontractors.

(5) Each MCO must have a grievance system in place for enrollees. The system must comply with the requirements of this section and the regulations of the state office of the insurance commissioner (OIC). If a conflict exists between the requirements of this chapter and OIC regulations, the requirements of this chapter take precedence. The MCO grievance system must include all of the following:

(a) A grievance process for complaints about any matter other than an action, as defined in WAC 388-538-050. See subsection (6) of this section for this process;

(b) An appeal process for an action, as defined in WAC 388-538-050. See subsection (7) of this section for the standard appeal process and subsection (8) of this section for the expedited appeal process;

(c) Access to the department's hearing process for actions as defined in WAC 388-538-050. The department's hearing process described in chapter 388-02 WAC applies to this chapter. Where conflicts exist, the requirements in this chapter take precedence. See WAC 388-538-112 for the department's hearing process for MCO enrollees;

(d) Access to an independent review (IR) as described in RCW 48.43.535, for actions as defined in WAC 388-538-050 (see WAC 388-538-112 for additional information about the IR); and

(e) Access to the board of appeals (BOA) for actions as defined in WAC 388-538-050 (also see chapter 388-02 WAC and WAC 388-538-112).

(6) The MCO grievance process:

(a) Only an enrollee may file a grievance with an MCO; a provider may not file a grievance on behalf of an enrollee.

(b) To ensure the rights of MCO enrollees are protected, each MCO's grievance process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's grievance process, including how to use the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) The MCO must give enrollees any assistance necessary in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers).

(e) The MCO must acknowledge receipt of each grievance either orally or in writing, and each appeal in writing, within five working days.

(f) The MCO must ensure that the individuals who make decisions on grievances are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are healthcare professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) A grievance regarding denial of an expedited resolution of an appeal; or

(B) A grievance involving clinical issues.

(g) The MCO must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.

(7) The MCO appeal process:

(a) An MCO enrollee, or the enrollee's representative with the enrollee's written consent, may appeal an MCO action.

(b) To ensure the rights of MCO enrollees are protected, each MCO's appeal process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's appeal process and the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) For standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety calendar days of the date on the MCO's notice of action. This also applies to an enrollee's request for an expedited appeal.

(e) For appeals for termination, suspension, or reduction of previously authorized services, if the enrollee is requesting continuation of services, the enrollee must file an appeal within ten calendar days of the date of the MCO mailing the notice of action. Otherwise, the time frames in subsection (7)(d) of this section apply.

(f) The MCO's notice of action must:

(i) Be in writing;

(ii) Be in the enrollee's primary language and be easily understood as required in 42 C.F.R. 438.10 (c) and (d);

(iii) Explain the action the MCO or its contractor has taken or intends to take;

(iv) Explain the reasons for the action;

(v) Explain the enrollee's or the enrollee's representative's right to file an MCO appeal;

(vi) Explain the procedures for exercising the enrollee's rights;

(vii) Explain the circumstances under which expedited resolution is available and how to request it (also see subsection (8) of this section);

(viii) Explain the enrollee's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services (also see subsection (9) of this section); and

(ix) Be mailed as expeditiously as the enrollee's health condition requires, and as follows:

(A) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(B) For standard service authorization decisions that deny or limit services, not to exceed fourteen calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days if the enrollee or provider requests extension. If the request for extension is granted, the MCO must:

(I) Give the enrollee written notice of the reason for the decision for the extension and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(II) Issue and carry out the determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(C) For termination, suspension, or reduction of previously authorized services, ten days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. 431.213 and 431.214 are met. The notice must be mailed by a method which certifies receipt and assures delivery within three calendar days.

(D) For expedited authorization decisions, in cases where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, no later than three calendar days after receipt of the request for service.

(g) The MCO must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).

(h) The MCO must acknowledge receipt of each appeal.

(i) The MCO must ensure that the individuals who make decisions on appeals are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are healthcare professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) An appeal of a denial that is based on lack of medical necessity; or

(B) An appeal that involves clinical issues.

(j) The process for appeals must:

(i) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing, unless the enrollee or provider requests an expedited resolution. Also see subsection (8) for information on expedited resolutions;

(ii) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution;

(iii) Provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process; and

(iv) Include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

(k) MCOs must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following time frames:

(i) For standard resolution of appeals and notice to the affected parties, no longer than forty-five calendar days from the day the MCO receives the appeal. This time frame may not be extended.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal.

(iii) For appeals for termination, suspension, or reduction of previously authorized services, no longer than forty-five calendar days from the day the MCO receives the appeal.

(l) The notice of the resolution of the appeal must:

(i) Be in writing. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice (also see subsection (8) of this section).

(ii) Include the results of the resolution process and the date it was completed.

(iii) For appeals not resolved wholly in favor of the enrollee:

(A) Include information on the enrollee's right to request a department hearing and how to do so (also see WAC 388-538-112);

(B) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request (also see subsection (9) of this section); and

(C) Inform the enrollee that the enrollee may be held liable for the cost of services received while the hearing is pending, if the hearing decision upholds the MCO's action (also see subsection (10) of this section).

(m) If an MCO enrollee does not agree with the MCO's resolution of the appeal, the enrollee may file a request for a department hearing within the following time frames (see WAC 388-538-112 for the department's hearing process for MCO enrollees):

(i) For hearing requests regarding a standard service, within ninety days of the date of the MCO's notice of the resolution of the appeal.

(ii) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, within

ten days of the date on the MCO's notice of the resolution of the appeal.

(n) The MCO enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department.

(8) The MCO expedited appeal process:

(a) Each MCO must establish and maintain an expedited appeal review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) When approving an expedited appeal, the MCO will issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.

(c) The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(d) If the MCO denies a request for expedited resolution of an appeal, it must:

(i) Transfer the appeal to the time frame for standard resolution; and

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

(9) Continuation of previously authorized services:

(a) The MCO must continue the enrollee's services if all of the following apply:

(i) The enrollee or the provider files the appeal on or before the later of the following:

(A) Unless the criteria in 42 C.F.R. 431.213 and 431.214 are met, within ten calendar days of the MCO mailing the notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days; or

(B) The intended effective date of the MCO's proposed action.

(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(iii) The services were ordered by an authorized provider;

(iv) The original period covered by the original authorization has not expired; and

(v) The enrollee requests an extension of services.

(b) If, at the enrollee's request, the MCO continues or reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the appeal;

(ii) Ten calendar days pass after the MCO mails the notice of the resolution of the appeal and the enrollee has not requested a department hearing (with continuation of services until the department hearing decision is reached) within the ten days;

(iii) Ten calendar days pass after the state office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee and the enrollee has not requested an independent review (IR) within the ten days (see WAC 388-538-112);

(iv) Ten calendar days pass after the IR mails a decision adverse to the enrollee and the enrollee has not requested a review with the board of appeals within the ten days (see WAC 388-538-112);

(v) The board of appeals issues a decision adverse to the enrollee (see WAC 388-538-112); or

(vi) The time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal upholds the MCO's action, the MCO may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

(10) Effect of reversed resolutions of appeals:

(a) If the MCO or OAH reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) If the MCO or OAH reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-110, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-110, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-110, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-110, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-110, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

WAC 388-538-111 Primary care case management (PCCM) grievances and appeals. (1) This section contains information about the grievance system for primary care case management (PCCM) enrollees, which includes grievances and appeals. See WAC 388-538-110 for information about the grievance system for managed care organization (MCO) enrollees.

(2) A PCCM enrollee may voice a grievance or file an appeal, either orally or in writing. PCCM enrollees use the department's grievance and appeal processes.

(3) The grievance process for PCCM enrollees;

(a) A PCCM enrollee may file a grievance with the department. A provider may not file a grievance on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (7)(c).

(c) When a PCCM enrollee files a grievance with the department, the enrollee is entitled to:

(i) Any reasonable assistance in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers);

(ii) Acknowledgment of the department's receipt of the grievance;

(iii) A review of the grievance. The review must be conducted by a department representative who was not involved in the grievance issue; and

(iv) Disposition of a grievance and notice to the affected parties within ninety days of the department receiving the grievance.

(4) The appeal process for PCCM enrollees:

(a) A PCCM enrollee may file an appeal of a department action with the department. A provider may not file an appeal on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (8)(c).

(c) The appeal process for PCCM enrollees follows that described in chapter 388-02 WAC. Where a conflict exists, the requirements in this chapter take precedence.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-111, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-111, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-111, filed 9/2/03, effective 10/3/03.]

WAC 388-538-112 The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions. (1) The hearing process described in chapter 388-02 WAC applies to the hearing process described in this chapter. Where a conflict exists, the requirements in this chapter take precedence.

(2) A managed care organization (MCO) enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department. See WAC 388-538-110 for the MCO grievance system.

(3) If an MCO enrollee does not agree with the MCO's resolution of the enrollee's appeal, the enrollee may file a request for a department hearing within the following time frames:

(a) For hearing requests regarding a standard service, within ninety calendar days of the date of the MCO's notice of the resolution of the appeal.

(b) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, and the enrollee is requesting continuation of services, within ten calendar days of the date on the MCO's notice of the resolution of the appeal.

(4) The entire appeal and hearing process, including the MCO appeal process, must be completed within ninety calendar days of the date the MCO enrollee filed the appeal with the MCO, not including the number of days the enrollee took to subsequently file for a department hearing.

(5) Expedited hearing process:

(a) The office of administrative hearings (OAH) must establish and maintain an expedited hearing process when the enrollee or the enrollee's representative requests an expedited hearing and OAH indicates that the time taken for a standard resolution of the claim could seriously jeopardize the enrollee's life or health and ability to attain, maintain, or regain maximum function.

(b) When approving an expedited hearing, OAH must issue a hearing decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the case file and information from the MCO regarding the action and MCO appeal.

(c) When denying an expedited hearing, OAH gives prompt oral notice to the enrollee followed by written notice within two calendar days of request and transfer the hearing to the time frame for a standard service.

(6) Parties to the hearing include the department, the MCO, the enrollee, and the enrollee's representative or the representative of a deceased enrollee's estate.

(7) If an enrollee disagrees with the hearing decision, then the enrollee may request an independent review (IR) in accordance with RCW 48.43.535.

(8) If there is disagreement with the IR decision, any party may request a review by the department's board of appeals (BOA) within twenty-one days of the IR decision. The department's BOA issues the final administrative decision.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-112, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-112, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-112, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, and 74.09.450. 04-13-002, § 388-538-112, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-110, § 388-538-112, filed 9/2/03, effective 10/3/03.]

WAC 388-538-120 Enrollee request for a second medical opinion. (1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a participating provider. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with the department.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-120, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-120, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-120, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-120, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-120, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 388-538-130 Exemptions and ending enrollment in managed care. (1) The department exempts a client from mandatory enrollment in managed care or ends an enrollee's enrollment in managed care as specified in this section.

(2) A client or enrollee, or the client's or enrollee's representative as defined in RCW 7.70.065, may request the department to exempt or end enrollment in managed care as described in this section.

(a) If a client requests exemption prior to the enrollment effective date, the client is not enrolled until the department approves or denies the request.

(b) If an enrollee requests to end enrollment, the enrollee remains enrolled pending the department's final decision, unless staying in managed care would adversely affect the enrollee's health status.

(c) The client or enrollee receives timely notice by telephone or in writing when the department approves or denies the client's or enrollee's request. The department follows a telephone denial by written notification. The written notice contains all of the following:

(i) The action the department intends to take;

(ii) The reason(s) for the intended action;

(iii) The specific rule or regulation supporting the action;

(iv) The client's or enrollee's right to request a hearing; and

(v) A translation into the client's or enrollee's primary language when the client or enrollee has limited English proficiency.

(3) A managed care organization (MCO) or primary care case management (PCCM) provider may request the department to end enrollment. The request must be in writing and be sufficient to satisfy the department that the enrollee's behavior is inconsistent with the MCO's or PCCM provider's rules and regulations (e.g., intentional misconduct). The department does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrollee's health or the cost of meeting the enrollee's healthcare needs. The MCO or PCCM provider's request must include documentation that:

(a) The provider furnished clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the enrollee's behavior;

(b) Such evaluation either finds no treatable condition to be contributing, or after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and

(c) The enrollee received written notice of the provider's intent to request the enrollee's removal, unless the department has waived the requirement for provider notice because the enrollee's conduct presents the threat of imminent harm to others. The provider's notice must include:

(i) The enrollee's right to use the provider's grievance system as described in WAC 388-538-110 and 388-538-111; and

(ii) The enrollee's right to use the department's hearing process, after the enrollee has exhausted all grievance and appeals available through the provider's grievance system (see WAC 388-538-110 and 388-538-111 for provider grievance systems, and WAC 388-538-112 for the hearing process for enrollees).

(4) When the department receives a request from an MCO or PCCM provider to remove an enrollee from enrollment in managed care, the department attempts to contact the enrollee for the enrollee's perspective. If the department approves the request, the department sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes:

(a) The reason the department approved ending enrollment; and

(b) Information about the enrollee's hearing rights.

(5) The department will exempt a client from mandatory enrollment or end an enrollee's enrollment in managed care when any of the following apply:

(a) The client or enrollee is receiving foster care placement services from the division of children and family services (DCFS);

(b) The client has or the enrollee becomes eligible for medicare, basic health (BH), CHAMPUS/TRICARE, or any other third-party healthcare coverage comparable to the department's managed care coverage that would require exemption or involuntarily ending enrollment from:

(i) An MCO, in accordance with the department's managed care contract; or

(ii) A primary care case management (PCCM) provider, according to the department's PCCM contract.

(c) The enrollee is no longer eligible for managed care.

(6) The department will grant a client's request for exemption or an enrollee's request to end enrollment when:

(a) The client or enrollee is American Indian/Alaska native (AI/AN) as specified in WAC 388-538-060(2);

(b) The client or enrollee has been identified by the department as a child who meets the definition of "children with special healthcare needs";

(c) The client or enrollee is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date of the request; or

(d) The client or enrollee speaks limited English or is hearing impaired and the client or enrollee can communicate with a provider who communicates in the client's or enrollee's language or in American sign language and is not available through the MCO and the MCO does not have a provider available who can communicate in the client's language and an interpreter is not available.

(7) On a case-by-case basis, the department may grant a client's request for exemption or an enrollee's request to end enrollment when, in the department's judgment, the client or enrollee has a documented and verifiable medical condition, and enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) Upon request, the department may exempt the client or end enrollment for the period of time the circumstances or conditions that lead to exemption or ending enrollment are expected to exist. The department may periodically review those circumstances or conditions to determine if they continue to exist. If the department approves the request for a limited time, the client or enrollee is notified in writing or by

telephone of the time limitation, the process for renewing the exemption or the ending of enrollment.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-130, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-130, filed 1/12/06, effective 2/12/06; 03-18-111, § 388-538-130, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-130, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

WAC 388-538-140 Quality of care. (1) To assure that managed care enrollees receive quality healthcare services, the department requires managed care organizations (MCOs) to comply with quality improvement standards detailed in the department's managed care contract. MCO's must:

(a) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(b) Have effective means to detect over and under utilization of services;

(c) Maintain a system for provider and practitioner credentialing and recredentialing;

(d) Ensure that MCO subcontracts and the delegation of MCO responsibilities are in accordance with the department standards and regulations;

(e) Ensure MCO oversight of delegated entities responsible for any delegated activity to include:

(i) A delegation agreement with each entity describing the responsibilities of the MCO and the entity;

(ii) Evaluation of the entity prior to delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues out of compliance with the delegation agreement or the department's managed care contract specifications.

(f) Cooperate with a department-contracted, qualified independent external review organization (EQRO) conducting review activities as described in 42 C.F.R. 438.358;

(g) Have an effective mechanism to assess the quality and appropriateness of care furnished to enrollees with special healthcare needs;

(h) Assess and develop individualized treatment plans for enrollees with special healthcare needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;

(i) Submit annual reports to the department on performance measures as specified by the department;

(j) Maintain a health information system that:

(i) Collects, analyzes, integrates, and reports data as requested by the department;

(ii) Provides information on utilization, grievances and appeals, enrollees ending enrollment for reasons other than the loss of medicaid eligibility, and other areas as defined by the department;

(iii) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the department; and

(iv) Ensures data received from providers is adequate and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency.

(k) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing system changes to achieve improvement in service quality;

(iii) Evaluating the effectiveness of system changes;

(iv) Planning and initiating activities for increasing or sustaining performance improvement;

(v) Reporting each project status and the results as requested by the department; and

(vi) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year.

(l) Ensure enrollee access to healthcare services;

(m) Ensure continuity and coordination of enrollee care; and

(n) Maintain and monitor availability of healthcare services for enrollees.

(2) The department may:

(i) Impose intermediate sanctions in accordance with 42 C.F.R. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(ii) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and

(iii) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-140, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; 03-18-111, § 388-538-140, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-140, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-140, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

Chapter 388-539 WAC
HIV/AIDS RELATED SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-539-001 Purpose. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-001, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-050 Definitions. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-050, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00,

effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-0500 Coordinated community aids service alternatives (CCASA) program services. [00-11-183, recodified as § 388-539-0500, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-86-018, filed 10/23/90, effective 11/23/90.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.

388-539-0550 Payment—Coordinated community aids service alternatives (CCSA) program. [Statutory Authority: RCW 74.08.090. 01-02-075, § 388-539-0550, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-539-0550, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-87-048, filed 10/23/90, effective 11/23/90.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.

388-539-100 Eligibility. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-100, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

388-539-150 Premium payment. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

WAC 388-539-0200 AIDS—Health insurance premium payment program. (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for MAA's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

(a) Be diagnosed with AIDS as defined in WAC 246-100-011;

(b) Be a resident of the state of Washington;

(c) Be responsible for all, or part of, the health insurance premium payment (without MAA's help);

(d) Not be eligible for one of MAA's other medical programs;

(e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

(i) A home used as the person's primary residence; and

(ii) A vehicle used as personal transportation.

(3) MAA may contract with a not-for-profit community agency to administer the Aids health insurance premium payment program. MAA or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

(a) Cooperate with MAA's contractor;

(b) Cooperate with eligibility determination and redetermination process; and

(c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of MAA's medical programs may ask MAA to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) MAA sets a reasonable payment limit for health insurance premiums. MAA sets its limit by tracking the charges billed to MAA for MAA clients who have AIDS. MAA does not pay health insurance premiums that exceed fifty percent of the average of charges billed to MAA for its clients with AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.757. 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

WAC 388-539-0300 Case management for persons living with HIV/AIDS. MAA provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for MAA reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) MAA has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for MAA's Title XIX (medicaid) clients.

(3) HIV/AIDS case management agencies who serve MAA's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in MAA's reimbursement to providers. MAA's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing.);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving MAA reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills MAA. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

WAC 388-539-0350 HIV/AIDS case management reimbursement information. (1) MAA reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment - The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) MAA reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) MAA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month - Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. MAA reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month - Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, MAA may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) MAA limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. MAA limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case Management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill MAA for up to ninety days of monitoring:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) MAA reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

Chapter 388-540 WAC

KIDNEY DISEASE PROGRAM AND KIDNEY CENTER SERVICES

WAC

KIDNEY DISEASE PROGRAM (STATE FUNDED)

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-540-010 Services. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-010, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.-090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-020 Reimbursement. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-020, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-030 KDP eligibility requirements. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-030, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-040 Transfer of resources without adequate consideration. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-040, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.-090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-050 Fiscal information. [Statutory Authority: RCW 74.04.-050 and 74.08.090. 00-01-088, § 388-540-050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-060 KDP eligibility determination. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-060, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

KIDNEY DISEASE PROGRAM (STATE FUNDED)

WAC 388-540-001 Purpose. This section (WAC 388-540-001 through 388-540-065) contains rules for the state-funded kidney disease program (KDP). The kidney disease program is designed to help clients who have end-stage renal disease, but who do not meet the eligibility standards for medicaid.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-001, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 388-540-005 Definitions. The following definitions and those found in WAC 388-500-0005, apply to this chapter for the purpose of administering the kidney disease program.

"Adequate consideration" means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

"Application for eligibility" means the form provided by MAA, which the client completes and submits to the contracted kidney center to determine KDP eligibility;

"Application documentation" means either a "medicaid medical determination" letter from the DSHS community services office, or a KDP "client recertification waiver" form.

"Assets" means income, resources, or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

"Certification" means the **kidney center** has determined a client eligible for the KDP for a defined period of time;

"End-stage renal disease (ESRD)" means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life;

"KDP application period" means the time between the date the client signed the completed application for eligibility and the date the client is certified for participation in the program;

"KDP client" means a resident of the state who has a diagnosis of ESRD and meets the financial and medical eligibility criteria as determined by a KDP contractor;

"KDP client recertification waiver for medicaid review" means a KDP eligibility form that may in some circumstances be used in place of a "medicaid medical assistance determination letter."

"KDP contract manual" means a set of policies and procedures for contracted kidney centers;

"KDP contractor" means a kidney center or other ESRD facility that has contracted with the Washington state department of social and health services (DSHS), kidney disease program to provide ESRD-related services to KDP clients.

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide **ESRD** services;

(2) Promote and encourage home dialysis for a client when medically indicated; and

(3) For the purposes of WAC 388-540-032 through 388-540-060, it is a facility that has entered into a contract with Washington state department of social and health services (DSHS), kidney disease program to provide ESRD-related services.

"Kidney disease program (KDP)" means a state-funded program that provides financial assistance to eligible clients with the costs of **ESRD**-related medical care;

"Medicaid medical assistance determination letter" means a medical assistance client eligibility letter from the DSHS community services office.

"Resident" means a person who lives in Washington state on more than a temporary basis.

"Substantial financial change" means the increase or decrease of income or assets that may affect eligibility.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-005, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

WAC 388-540-015 Client eligibility for kidney disease program (KDP). Clients must meet the following criteria to be considered KDP eligible:

(1) Be a Washington state resident;

(2) Be diagnosed with end-stage renal disease (ESRD);

(3) Be determined ineligible for medicaid;

(4) Exhaust or be ineligible for all other resources providing similar benefits;

(5) Have countable income which is equal to or less than:

(a) Two hundred percent of the federal poverty level (FPL) or;

(b) Three hundred percent of the FPL with an annual deductible required equal to the income amount which is in excess of two hundred percent of the FPL.

(6) Have countable resources that are either equal to or less than fifteen thousand dollars, or are exempt. Exempt resources are:

(a) A home, defined as real property owned by a client as principal place of residence together with surrounding and contiguous property, not to exceed five acres;

(b) Household furnishings; and

(c) An automobile.

(7) The effective date of eligibility is the first day of the month the application for eligibility is signed by the client.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-015, filed 10/8/03, effective 11/8/03.]

WAC 388-540-025 Kidney disease program (KDP) eligibility determination. The kidney center and client must comply with the following rules to determine KDP eligibility:

(1) The KDP contractor must:

(a) Inform the client of the requirements for KDP eligibility as defined in this chapter and provide the client with necessary department forms and instructions;

(b) Determine client eligibility using department policies, rules, and instructions; and

(c) Forward the completed application for eligibility, and the application documentation to the KDP program manager at the medical assistance administration (MAA). (The KDP program manager may amend or terminate a client's certification period within thirty days of receipt if the application is incomplete or inaccurate.)

(2) A person applying for KDP must:

(a) Complete the application for eligibility and submit any necessary documentation to the kidney center;

(b) Apply for medicaid, obtain a written medicaid medical assistance determination letter, submit a copy to the kidney center; and

(c) Apply for medicare.

(3) A client reapplying for continued eligibility must:

(a) Complete the KDP application for eligibility and submit any documentation necessary to determine eligibility to the kidney center;

(b) Apply for medicaid forty-five days before the end of the KDP certification period, obtain a written medicaid eligibility determination, and submit a copy to the kidney center; or

(c) Have applied for medicaid within the previous five years and continue to be ineligible.

(4) The KDP application period is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a certification period for a client requesting recertification.

(5) The KDP contractor may request an extension of application time limits from MAA when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The KDP contractor certifies the client for no more than one year from the first day of the month of application, unless the client:

(a) Needs medical coverage for less than one year; or

(b) Has a substantial financial change, in which case the client must complete a new application for eligibility.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-025, filed 10/8/03, effective 11/8/03.]

WAC 388-540-035 Kidney disease program (KDP)—Transfer of resources without adequate consideration. A person may be ineligible for the KDP if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value within two years preceding the date of application, for the purpose of qualifying or continuing to qualify for the program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-035, filed 10/8/03, effective 11/8/03.]

WAC 388-540-045 Kidney disease program (KDP) provider requirements. (1) The KDP contractor must:

(a) Be a medicare-certified end-stage renal disease (ESRD) facility; and

(b) Have a valid KDP client services contract with the department.

(2) The KDP contractor must provide, directly or through an affiliate:

(a) Professional consultation, personal instructions, medical treatment and care, drug products and all supplies necessary for carrying out a medically-sound end-stage renal disease (ESRD) treatment program;

(b) Dialysis for clients with ESRD when medically indicated;

(c) Kidney transplant treatment, either directly or by referral, when medically indicated;

(d) Treatment for conditions directly related to ESRD such as anemia or venous access infections; and

(e) Supplies and equipment for home dialysis.

(3) The provider must maintain adequate records for audit and review purposes, including:

(a) Medical charts and records that meet the requirements of WAC 388-502-0020; and

(b) Eligibility determination records.

(4) The contractor must meet other obligations as required by their contract with the KDP program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-045, filed 10/8/03, effective 11/8/03.]

WAC 388-540-055 Kidney disease program (KDP) covered services. The KDP program covers the cost of health care services essential to the treatment of end stage renal disease (ESRD) and its complications. Covered services include:

(1) Mandatory services that must be provided by the KDP contractor:

(a) Dialysis:

(i) Center dialysis—Covers the cost of dialysis and related services provided in a kidney center;

(ii) Home dialysis—Covers the cost of providing dialysis and related services in the home; and

(iii) Dialysis while hospitalized—Covers the cost of dialysis and related services while the client is confined to an acute care facility and is unable to dialyze at his/her regular site.

(b) Medication—As defined in the approved drug list in the KDP manual.

(2) Optional services that may be provided by the KDP contractor:

(a) Venous access surgery—Covers costs associated with surgically preparing the client for dialysis and medical complications related to the venous access site;

(b) Laboratory tests and X rays considered to be part of the overall treatment plan for ESRD;

(c) Post-transplant visit to assess client's ESRD status; and

(d) Health insurance premiums including copays and deductibles, when found to be cost-effective.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-055, filed 10/8/03, effective 11/8/03.]

WAC 388-540-065 Kidney disease program (KDP)—Reimbursement. (1) The medical assistance administration (MAA) reimburses KDP contractors:

(a) Within the limits of legislative funding for the program;

(b) According to the terms of each kidney center's contract with the department; and

(c) According to the provisions of the KDP contract manual.

(2) The KDP contractor must submit the following documentation to MAA:

(a) A description of the services for which reimbursement is requested; and

(b) Statement of client's financial eligibility for the KDP.

(3) MAA limits KDP reimbursement for out-of-state services to fourteen days per calendar year. Reimbursement is paid only to KDP contractors. Out-of-state dialysis providers must operate under subcontract or agreement with an in-state KDP contractor in order to receive reimbursement under this program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-065, filed 10/8/03, effective 11/8/03.]

KIDNEY CENTER SERVICES

WAC 388-540-101 Purpose and scope. This section describes the medical assistance administration (MAA) reimbursement rules for free-standing kidney centers providing dialysis and end-stage renal disease services to MAA clients.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-101, filed 10/8/03, effective 11/8/03.]

WAC 388-540-105 Definitions. The following definitions and those found in WAC 388-500-0005, apply to this chapter.

"Acute dialysis" means dialysis given to patients who are not ESRD patients, but who require dialysis of temporary kidney failure due to a sudden trauma (e.g., traffic accident or ingestion of certain drugs, etc.).

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients.

"Agreement" means a written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining reimbursement for those services.

"Back-up dialysis" means dialysis given to a patient under special circumstances, in a situation other than the patient's usual dialysis environment. Examples are:

(1) Dialysis of a home dialysis patient in a dialysis facility when patient's equipment fails;

(2) Inhospital dialysis when the patient's illness requires more comprehensive care on an inpatient basis;

(3) Pre- and post-operative dialysis provided to transplant patients.

"Composite rate" means a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

"Continuous ambulatory peritoneal dialysis (CAPD)" means a type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at

home, using special supplies, but without the need for a machine. (See "Peritoneal dialysis.")

"Continuous cycling peritoneal dialysis (CCPD)" means a type of peritoneal dialysis where the patient dialyzes at home and utilizes an automated peritoneal cycler for delivering dialysis.

"Dialysate" means an electrolyte solution, containing elements such as potassium, sodium chloride, etc., surrounding the membrane or fibers and allowing exchange of substances with the patient's blood in the dialyzer.

"Dialysis" means a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

"Dialysis session" means the period of time beginning when the patient arrives at the facility and ending when the patient departs from the facility. In the case of home dialysis, the time period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine.

"Dialyzer" means the synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances, and replacing them with useful ones.

"Drug-related supplies" means nonpharmaceutical items necessary for administration or delivery of a drug.

"Durable medical equipment (DME)" means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"End-stage renal disease (ESRD)" means the stage of renal impairment that is irreversible and permanent, and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life.

"Epoetin alpha (EPO)" means the biologically engineered protein that stimulates the bone marrow to make new red blood cells. It is used in the treatment of anemia.

"Free-standing kidney center" means a limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services.

"Hemodialysis" means a method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Hemodialysis is usually done in a kidney center or facility. It can be done at home with a trained dialysis helper.

"Home dialysis" means any dialysis performed at home.

"Home dialysis helper" means a person trained to assist the client in home dialysis.

"In-facility dialysis," for the purpose of this chapter only, in-facility dialysis means dialysis of any type performed on the premises of a kidney center or other free-standing ESRD facility.

"Intermittent peritoneal dialysis (IPD)" means a type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity, allowed to remain there for a period of time, and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper.

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide ESRD services;

(2) Provide the services specified in this chapter; and

(3) Promote and encourage home dialysis for a client when medically indicated.

"Maintenance dialysis" means the usual periodic dialysis treatments given to a client who has ESRD.

"Peritoneal dialysis" means a procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis, and intermittent peritoneal dialysis.

"Self-dialysis unit" means a unit in a free-standing kidney center where dialysis is performed by an ESRD client who has completed training in self-dialysis.

"Standard ESRD lab tests" means certain laboratory tests that the Centers for medicare and medicaid include in their composite rate calculations. These tests are identified in MAA's kidney center billing instructions.

"Take home drugs" means outpatient prescription drugs that are administered outside of a provider's office.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-105, filed 10/8/03, effective 11/8/03.]

WAC 388-540-110 Eligibility. (1) To be eligible for the kidney center services described in this section, a client must be diagnosed with end-stage renal disease (ESRD) or acute renal failure and be covered under one of the following programs:

(a) Categorically needy program (CNP);

(b) Children's health insurance program (CHIP);

(c) General assistance-unemployable (GAU);

(d) Limited casualty program—Medically needy program (MNP);

(e) Alien emergency medical; or

(f) Qualified mrdicare beneficiary (QMB)—(MAA pays only for medicare premium, coinsurance and deductible).

(2) Managed care enrollees must have dialysis services arranged directly through their designated plan.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-110, filed 10/8/03, effective 11/8/03.]

WAC 388-540-120 Provider requirements. To receive reimbursement from the medical assistance administration (MAA) for providing care to MAA clients, a kidney center must:

(1) Be a medicare-certified end-stage renal disease (ESRD) facility and have a signed core provider agreement with MAA (see chapter 388-502 WAC);

(2) Meet requirements found in chapter 388-502 WAC;

(3) Provide only those services within the scope of their provider's license; and

(4) Provide, either directly or through an affiliate, all physical facilities, professional consultation, personal

instructions, medical treatment, care, and all supplies necessary for carrying out an medically sound ESRD treatment program, including all of the following:

(a) Dialysis for ESRD clients;

(b) Kidney transplant treatment, either directly or by referral, for ESRD clients when medically indicated;

(c) Treatment for conditions directly related to ESRD;

(d) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and

(e) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-120, filed 10/8/03, effective 11/8/03.]

WAC 388-540-130 Covered services. (1) The department covers the following services and supplies subject to the restrictions and limitations in this section and other applicable published WAC:

(a) In-facility dialysis;

(b) Home dialysis;

(c) Training for self-dialysis;

(d) Home dialysis helpers;

(e) Dialysis supplies;

(f) Diagnostic lab work;

(g) Treatment for anemia; and

(h) Intravenous drugs.

(2) Covered services are subject to the limitations specified by the department. Providers must obtain prior authorization (PA) or expedited prior authorization (EPA) before providing services that exceed specified limits in quantity, frequency or duration (refer to WAC 388-501-0165 and 388-501-0169).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-540-130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-130, filed 10/8/03, effective 11/8/03.]

WAC 388-540-140 Noncovered services. (1) The department does not reimburse kidney centers for the following:

(a) Blood and blood products (refer to WAC 388-540-190);

(b) Personal care items such as slippers, toothbrushes, etc.; or

(c) Additional staff time or personnel costs. Staff time is paid through the composite rate. Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).

(2) The department evaluates a request for any service listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-540-140, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-140, filed 10/8/03, effective 11/8/03.]

WAC 388-540-150 Reimbursement—General. (1) Kidney center services described in this section are paid by one of two methods:

(a) **Composite rate payments—**This is a payment method in which all standard equipment, supplies and services are calculated into a blended rate.

(i) A single dialysis session and related services are reimbursed through a single composite rate payment (refer to WAC 388-540-160).

(ii) Composite rate payments for continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) are limited to thirty-one per month for an individual client.

(iii) Composite rate payments for all other types of dialysis sessions are limited to fourteen per month for an individual client.

(b) **Noncomposite rate payments—**End-stage renal disease (ESRD) services and items covered by the department but not included in the composite rate are billed and paid separately (refer to WAC 388-540-170).

(2) **Limitation extension request—**The department evaluates billings for covered services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary under the provisions of WAC 388-501-0165 and 388-501-0169.

(3) **Take-home drugs—**The department reimburses kidney centers for take-home drugs only when they meet the conditions described in WAC 388-540-170(1). Other drugs for at-home use must be billed by a pharmacy and be subject to the department's pharmacy rules.

(4) **Medical nutrition—**Medical nutrition products must be billed by a pharmacy or a durable medical equipment (DME) provider.

(5) **Medicare eligible clients—**The department does not reimburse kidney centers as a primary payer for medicare eligible clients.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-540-150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-150, filed 10/8/03, effective 11/8/03.]

WAC 388-540-160 Items and services included in the composite rate. (1) The following equipment, supplies, and services for in-facility and home dialysis are included in the composite rate:

(a) Medically necessary dialysis equipment;

(b) All dialysis services furnished by the facility's staff;

(c) Standard end-stage renal disease laboratory tests (refer to WAC 388-540-180);

(d) Home dialysis support services including delivery, installation, and maintenance of equipment;

(e) Purchase and delivery of all necessary dialysis supplies;

(f) Declotting of shunts and any supplies used to declot shunts;

(g) Oxygen and the administration of oxygen;

(h) Staff time used to administer blood and nonroutine parenteral items;

(i) Noninvasive vascular studies; and

(j) Training for self-dialysis and home dialysis helpers.

(2) The medical assistance administration (MAA) issues a composite rate payment only when all of the above items

and services are furnished or available at each dialysis session.

(3) If the facility fails to furnish or have available any of the above items, MAA does not pay for any part of the items and services that were furnished.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-160, filed 10/8/03, effective 11/8/03.]

WAC 388-540-170 Items and services not included in the composite rate. The following items and services are not included in the composite rate and must be billed separately, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) Drugs related to treatment, including but not limited to epoetin alpha (EPO) and diazepam. The drug must:

(a) Be prescribed by a physician;

(b) Meet the rebate requirements described in WAC 388-530-1125; and

(c) Meet the requirements of WAC 246-905-020 when provided for home use.

(2) Supplies used to administer drugs and blood;

(3) Blood processing fees charged by the blood bank (refer to WAC 388-540-190); and

(4) Home dialysis helpers.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-170, filed 10/8/03, effective 11/8/03.]

WAC 388-540-180 Laboratory services. (1) Laboratory services included in the composite rate, performed by either the facility or an independent laboratory, must not be billed separately except as provided for in (b) of this subsection:

(a) Standard end-stage renal disease (ESRD) lab tests are included in the composite rate when performed at recommended intervals (see billing instructions for current list).

(b) The standard ESRD lab tests referred to in (a) of this subsection can be reimbursed separately from the composite rate only when it is medically necessary to test more frequently:

(i) Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of end-stage renal disease is not sufficient;

(ii) The claim must include information on the nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of the test(s); or

(iii) An ICD-9CM diagnosis code may be shown in lieu of a narrative description.

(2) All separately billable, ESRD laboratory services must be billed by and reimbursed to the lab that performs the test.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-180, filed 10/8/03, effective 11/8/03.]

WAC 388-540-190 Blood products and services. (1) The medical assistance administration (MAA) reimburses free-standing kidney centers for:

(a) Blood processing and other fees assessed by nonprofit blood centers that do not charge for the blood or blood products themselves; and

(b) Costs incurred by the center to administer its in-house blood procurement program.

(2) MAA does not reimburse centers for blood or blood products (refer to WAC 388-550-6500).

(3) Staff time used to administer blood or blood products is reimbursed only through the composite rate (refer to WAC 388-540-150 and 388-540-160).

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-190, filed 10/8/03, effective 11/8/03.]

WAC 388-540-200 Epoetin alpha (EPO) therapy. The medical assistance administration (MAA) reimburses the kidney center for EPO therapy when:

(1) Administered in the kidney center to a client:

(a) With a hematocrit less than thirty-three percent or a hemoglobin less than eleven when therapy is initiated;

(b) Continuing EPO therapy with a hematocrit between thirty and thirty-six percent; or

(c) Medical justification documented in the client's record is required for hematocrits greater than thirty-six or hemaglobins greater then twelve. Medical justification includes:

(i) Documentation that dose is being titrated downward to bring a patient's hematocrit back within target range; or

(ii) Documentation that it is medically necessary for the client to have a target hematocrit greater than thirty-six percent.

(2) Provided to a home dialysis client:

(a) Under the same hematocrit/hemoglobin guidelines as stated in (1)(a) and (b) of this section; and

(b) When permitted by Washington board of pharmacy rules. (Refer to WAC 246-905-020 Home dialysis program—Legend drugs.)

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-200, filed 10/8/03, effective 11/8/03.]

WAC 388-540-210 Injectable drugs given in the kidney center. Injectable drugs administered in the kidney center are reimbursed up to the medical assistance administration's (MAA) published maximum fees.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-210, filed 10/8/03, effective 11/8/03.]

Chapter 388-542 WAC

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-542-0100 CHIP scope of care. [Statutory Authority: RCW 74.08.-090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0100, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]-522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0100, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0100, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0125 Access to care. [Statutory Authority: RCW 74.08.090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0125, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0125, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0125, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0150 Client eligibility requirements for CHIP. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0150, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0150, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0200 CHIP enrollment. [Statutory Authority: RCW 74.09.-080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0200, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0200, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0220 Ending CHIP client eligibility. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0220, filed 12/14/01, effective 1/14/02.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0250 CHIP client costs. [Statutory Authority: RCW 74.09.-080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0250, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0250, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0275 Reimbursement. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0275, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0275, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0500 Managed care rules that apply to CHIP. [Statutory Authority: RCW 74.08.090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0500, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.-080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0500, filed 12/14/01, effective 1/14/02.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

WAC 388-542-0010 Purpose and scope of premium-based children's healthcare programs. The department administers premium-based children's healthcare through a combination of state and federal funding sources as described below:

(1) Federally matched healthcare coverage as authorized by Title XXI of the Social Security Act (SCHIP) and RCW 74.09.450 for citizen and federally qualified immigrant children whose family income is above two hundred percent of the federal poverty level (FPL) but is not above two hundred fifty percent of the FPL.

(2) State funded healthcare coverage for noncitizen children with family income above two hundred percent FPL, but not above two hundred fifty percent FPL, who are ineligible for Title XXI federally matched children's healthcare coverage due to immigration issues.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0010, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.050, and Title XXI of the Social Security Act. 06-15-134, § 388-542-0010, filed 7/19/06, effective 8/19/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0010, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0020 Other rules that apply to premium-based children's healthcare programs. In addition to the rules of this chapter, premium-based children's healthcare clients are subject to the following rules:

(1) Chapter 388-538 WAC, Managed care (except WAC 388-538-061, 388-538-063, and 388-538-065) if the child is covered under federally matched CN coverage;

(2) WAC 388-505-0210(4), Children's healthcare program eligibility;

(3) WAC 388-505-0211, Premium requirements for premium-based children's healthcare programs;

(4) WAC 388-416-0015(12), Certification periods for categorically needy (CN) scope of care medical assistance programs; and

(5) WAC 388-418-0025, Effect of changes on medical program eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0020, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-07-014, § 388-542-0020, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0020, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0050 Definitions for premium-based children's healthcare programs. The following definitions, as well as those found in WAC 388-538-050 and in 388-500-0005 Medical definitions, apply to premium-based children's healthcare programs.

"Creditable coverage" means most types of public and private health coverage, except Indian health services, that provides access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under premium-based children's healthcare programs. "Creditable coverage" is described in 42 U.S.C. Sec. 1397jj.

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long

as there remains a contribution toward the premiums by the employer or union.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0050, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0050, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-450. 00-07-103, § 388-542-0050, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0300 Waiting period for premium-based healthcare programs coverage following employer coverage. (1) The department requires applicants to serve a waiting period of four full consecutive months before receiving premium-based children's healthcare programs coverage if the client or family:

(a) Chooses to end employer sponsored dependent coverage. The waiting period begins the day after the employment-based coverage ends; or

(b) Fails to exercise an optional coverage extension (e.g., COBRA) that meets the following conditions. The waiting period begins on the day there is a documented refusal of the coverage extension when the extended coverage is:

(i) Subsidized in part or in whole by the employer or union;

(ii) Available and accessible to the applicant or family; and

(iii) At a monthly cost to the family meeting the limitation of subsection (2)(b)(iv).

(2) The department does not require a waiting period prior to coverage under premium-based children's healthcare programs when:

(a) The client or family member has a medical condition that, without treatment, would be life-threatening or cause serious disability or loss of function; or

(b) The loss of employer-sponsored dependent coverage is due to any of the following:

(i) Loss of employment with no post-employment subsidized coverage as described in subsection (1)(b);

(ii) Death of the employee;

(iii) The employer discontinues employer-sponsored dependent coverage;

(iv) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is fifty dollars per month or more;

(v) The plan terminates employer-sponsored dependent coverage for the client because the client reached the maximum lifetime coverage amount;

(vi) Coverage under a COBRA extension period expired;

(vii) Employer-sponsored dependent coverage is not reasonably available (e.g., client would have to travel to another city or state to access care); or

(viii) Domestic violence caused the loss of coverage for the victim.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0300, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0300, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0300, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.-450. 00-07-103, § 388-542-0300, filed 3/17/00, effective 4/17/00.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

WAC 388-543-1000 Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

"Artificial limb" - See "prosthetic device."

"Augmentative communication device (ACD)" - See "speech generating device (SGD)."

"Base year" means the year of the data source used in calculating prices.

"By report (BR)" means a method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.

"Date of delivery" means the date the client actually took physical possession of an item or equipment.

"Disposable supplies" means supplies which may be used once, or more than once, but are time limited.

"Durable medical equipment (DME)" means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"EPSDT" - See WAC 388-500-0005.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization.

"Fee-for-service (FFS)" means the general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.

"Health care financing administration common procedure coding system (HCPCS)" means a coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"House wheelchair" means a nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Limitation extension" means a process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization.

"Nonreusable supplies" are disposable supplies, which are used once and discarded.

"Manual wheelchair" - See "wheelchair - manual."

"Medical supplies" means supplies that are:

(1) Primarily and customarily used to service a medical purpose; and

(2) Generally not useful to a person in the absence of illness or injury.

"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.

"Personal or comfort item" means an item or service which primarily serves the comfort or convenience of the client.

"Personal computer (PC)" means any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations).

"Power-drive wheelchair" - See "wheelchair - power."

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165.

"Prosthetic device" or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, 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.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involve.

"Reusable supplies" are supplies which are to be used more than once.

"Scooter" means a federally-approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

"Specialty bed" means a pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" means an electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Three- or four-wheeled scooter" means a three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

"Trendelenburg position" means a position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" means the amount the provider typically charges to fifty percent or more of his or her nonmedicaid clients, including clients with other third-party coverage.

"Warranty-wheelchair" means a warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase.

"Wheelchair - manual" means a federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(1) Standard:

(a) Usually is not capable of being modified;

(b) Accommodates a person weighing up to two hundred fifty pounds; and

(c) Has a warranty period of at least one year.

(2) Lightweight:

(a) Composed of lightweight materials;

(b) Capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds; and

(d) Usually has a warranty period of at least three years.

(3) High strength lightweight:

(a) Is usually made of a composite material;

(b) Is capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds;

(d) Has an extended warranty period of over three years; and

(e) Accommodates the very active person.

(4) Hemi:

(a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(8) Heavy duty:

(a) Specifically manufactured to support a person weighing up to three hundred pounds; or

(b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(10) Custom heavy duty:

(a) Specifically manufactured to support a person weighing over three hundred pounds; or

(b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(11) Custom manufactured specially built:

(a) Ordered for a specific client from custom measurements; and

(b) Is assembled primarily at the manufacturer's factory.

"Wheelchair - power" means a federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(a) Alternative driving controls; and

(b) Power recline and tilt-in-space systems.

(2) Noncustom power: Does not need special positioning or controls and has a standard frame.

(3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1000, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1000, filed 12/13/00, effective 1/13/01.]

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 and 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 following 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 nonwoven, 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/adapter; 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/adapter, 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 388-543-1200 Providers who are eligible to provide services. (1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to an MAA client to meet all of the following. The provider must:

(a) Have the proper business license;

(b) Have appropriately trained qualified staff; and

(c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

(a) DME providers for DME and related repair services;

(b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;

(c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;

(d) Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's **resource based relative value scale (RBRVS)** fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(3) MAA terminates from medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1225 Provider requirements. (1) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics and orthotics, medical supplies and related items must meet the general provider documentation and record retention requirements in WAC 388-502-0020. In addition to these requirements, the medical assistance administration (MAA) requires providers to furnish, upon request, documentation of proof of delivery as stated in subsections (2) and (3) of this section.

(2) 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 when MAA requests that information. All of the following apply:

(a) MAA requires a delivery slip as proof of delivery, and it must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For durable medical equipment that would require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to MAA, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or authorized representative; or

(ii) For nondurable medical supplies for which MAA has established a monthly maximum, on or after the date the item was received by the client or authorized representative.

(3) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must be able to furnish proof of delivery that the client received the equipment, when MAA requests that information. All of the following apply:

(a) MAA requires the delivery service tracking slip as proof of delivery, and it must include:

(i) The client's name or a reference to the client's package(s);

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) MAA requires the supplier's shipping invoice as proof of delivery, and it must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand name(s) of the items being shipped; and

(iv) For durable medical equipment that would require future repairs, include the serial number.

(c) When the provider submits a claim for payment to MAA, the date of service on the claim must be the shipping date.

(4) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(5) Providers must obtain prior authorization on any item that requires such before delivering that item to the client. The item must be delivered to the client before the provider bills MAA.

(6) MAA does not pay for DME and related supplies, prosthetics and orthotics, medical supplies and related items furnished to MAA clients when:

(a) The medical professional who provides medical justification to MAA for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of DME and related supplies, prosthetics and orthotics, medical supplies, and related items.

(7) See WAC 388-502-0100, 388-502-0110, 388-502-0120, and 388-502-0130 for provider payment requirements.

(8) See WAC 388-502-0150 and 388-502-0160 for provider billing requirements.

(9) See WAC 388-502-0220, 388-502-0230, 388-502-0240, and 388-502-0260 for provider appeal requirements.

[Statutory Authority: RCW 74.08.090, 74.09.530. 03-05-051, § 388-543-1225, filed 2/14/03, effective 3/17/03.]

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, prosthetics, 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 waivered 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 peridontal 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 388-543-1400 General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services. (1) MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

(a) The provider meets all of the conditions in WAC 388-502-0100; and

(b) MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

(i) Hospice providers' per diem reimbursement;

(ii) Hospitals' diagnosis related group (DRG) reimbursement;

(iii) Managed care plans' capitation rate; and

(iv) Nursing facilities' per diem rate.

(2) MAA sets maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and

related services using available published information, such as:

(a) Commercial data bases for price comparisons;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

(3) MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if MAA determines that such actions are in the best interest of its clients.

(4) MAA updates the maximum allowable fees for DME and supplies and prosthetic/orthotic devices no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment and prosthetic/orthotic devices at different times during the year.

(5) A provider must not bill MAA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(6) MAA's maximum payment for medical equipment and supplies is the lesser of either of the following:

(a) Providers' **usual and customary charges**; or

(b) Established rates, except as provided in subsection (7)(a) of this section.

(7) If a client is eligible for both medicare and medicaid, the following apply:

(a) MAA requires a provider to accept medicare assignment before any medicaid reimbursement;

(b) If the service provided is covered by medicare and medicaid, MAA pays:

(i) The deductible and coinsurance up to medicare's allowed amount or MAA's allowed amount, whichever is less; or

(ii) For services that are not covered by medicare but are covered by MAA, if medically necessary.

(8) MAA may pay for medical services rendered to a client only when MAA is the payor of last resort.

(9) MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider.

(10) See WAC 388-543-2100, 388-543-2500, 388-543-2700, and 388-543-2900 for other reimbursement methodologies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1500 When MAA purchases DME and related supplies, prosthetics, and orthotics. (1) Durable medical equipment (DME) and related supplies, prosthetics, and orthotics purchased by MAA for a client is the client's property.

(2) MAA's reimbursement for covered DME and related supplies, prosthetics, and orthotics includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the **date of delivery**. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(3) MAA requires a provider to furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties.

(4) MAA requires a dispensing provider to include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased, as provided under WAC 388-543-1700(3).

(5) MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

(a) Any DME that MAA considers purchased according to WAC 388-543-1700 requires repair during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(6) MAA charges the dispensing provider fifty percent of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

(a) Any medical equipment that MAA considers purchased according to WAC 388-543-1700 requires replacement during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) Purchase orders:

(a) MAA rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(i) Dies;

(ii) Loses medical eligibility;

(iii) Becomes covered by a hospice agency; or

(iv) Becomes covered by an MAA managed care plan. Refer to subsection (7)(c) of this section.

(b) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per (a) of this subsection, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

(c) A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

(i) MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

(ii) MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

(iii) The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1500, 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 388-543-1800 Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services. (1) A provider/vendor may obtain **expedited prior authorization (EPA)** from MAA according to WAC 388-543-1900.

(2) For prior authorization requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

(3) When MAA receives an initial request for prior authorization, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

(4) MAA authorizes BR items that require prior authorization and are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medical necessity is established and the provider furnishes all of the following information to MAA:

(a) A detailed description of the item or service to be provided;

(b) The cost or charge for the item;

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and

(d) A detailed explanation of how the requested item differs from an already existing code description.

(5) MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(6) MAA prior authorizes payment for repair and modification of client-owned equipment only when the criteria in subsection (1) of this section are met. Requests for repairs must include the information listed in subsection (5) of this section.

(7) MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for prior authorization and explain the following:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet those medical needs.

(8) MAA informs the provider and the client of a less costly alternative from MAA's manufacturers' literature on file when an MAA denial of a request is based on a less costly, equally effective alternative.

(9) A provider may resubmit a request for prior authorization for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

(10) MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1800, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1900 Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services. (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes. MAA allows payment during a continuous twelve-month period for this process.

(2) MAA requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in MAA published DME-related billing instructions. The authorization number must be used when the provider bills MAA.

(3) The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code or a requested rental exceeds the limited rental period indicated.

(4) Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA in subsection (2) of this section.

(5) MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1900, 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 participate 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 388-543-2100 Wheelchairs—Reimbursement methodology. (1) MAA reimburses a DME provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) The client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) For wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses either:

(a) The medicare fees that are current on April 1 of each year; or

(b) MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the **base year,** or the invoice for the specific item. MAA uses the following percentages:

(i) For basic standard wheelchairs, sixty-five percent;

(ii) For add-on accessories and parts, eighty-four percent;

(iii) For upcharge modifications and cushions, eighty percent;

(iv) For all other manual wheelchairs, eighty percent; and

(v) For all other power-drive wheelchairs, eighty-five percent.

(3) MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or medicare rates.

(4) MAA evaluates and updates the wheelchair fee schedule once per year.

(5) MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2200 Speech generating devices (SGD). (1) MAA considers all requests for speech generating devices (SGDs) on a case-by-case basis. The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

(2) In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment, and have one of the following characteristics. For the purposes of this section, MAA uses the medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

(a) Digitized speech output, using pre-recorded messages;

(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or

(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

(3) MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

(a) A detailed description of the client's therapeutic history, including, at a minimum:

(i) The medical diagnosis;

(ii) A physiological description of the underlying disorder;

(iii) A description of the functional limitations; and

(iv) The prognosis for improvement or degeneration.

(b) A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

(i) If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, an assessment by the prescribing physician, licensed occupational therapist or physical therapist;

(ii) Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;

(iii) The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

(iv) An assessment of whether the client's daily communication needs could be met using other natural modes of communication;

(v) A description of the functional communication goals expected to be achieved, and treatment options;

(vi) Documentation that the client's speaking needs cannot be met using natural communication methods; and

(vii) Documentation that other forms of treatment have been ruled out.

(c) The provider has shown or has demonstrated all of the following:

(i) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;

(ii) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and

(iii) The client's treatment plan includes a training schedule for the selected device.

(d) A prescription for the SGD from the client's treating physician.

(4) MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.

(5) MAA covers SGDs only once every two years for a client who meets the criteria in subsection (3) of this section. MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the criteria in this subsection based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

(6) Clients who are eligible for both medicare and medicaid must apply first to medicare for an SGD. If medicare denies the request and the client requests an SGD from MAA, MAA evaluates the request based on medical necessity and the requirements in this section. The request for an SGD must meet the authorization requirements in this section.

[Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-2200, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-2200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2300 Bathroom/shower equipment. (1) MAA considers a caster-style shower commode chair as the primary option for clients.

(2) MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:

(a) Is able to propel the equipment; and

(b) Has special positioning needs that cannot be met by a caster-style chair.

(3) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2400 Hospital beds. (1) Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:

(a) MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary;

(b) MAA determines rental on a month-to-month basis if a client's prognosis is poor;

(c) MAA considers a purchase if the need is for more than six months;

(d) If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.

(2) MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

(3) MAA considers a full electric hospital bed only if the client meets all of the following criteria:

(a) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

(b) The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(c) The client's medical condition requires immediate position changes;

(d) The client is able to operate the controls independently; and

(e) The client needs to be in the **Trendelenburg position**.

(4) All other circumstances for hospital beds will be considered on a case-by-case basic, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2500 Reimbursement methodology for other durable medical equipment. (1) For the purposes of this section, MAA uses the following terms:

(a) **"Other durable medical equipment (other DME)"** means all durable medical equipment, excluding wheelchairs and related items.

(b) **"Pricing cluster"** means a group of discounted manufacturers' list prices and/or dealer's costs for brands/models of other DME that MAA uses to calculate the reimbursement rate for a procedure code that does not have a fee established by medicare. MAA uses the discounted manufacturer list price for a brand/model unless that price is not available.

(2) MAA establishes reimbursement rates for purchased other DME.

(a) For other durable medical equipment that have a medicare rate established for a new purchase, MAA uses the rate that is in effect on January first of the year in which MAA sets the reimbursement.

(b) For other durable medical equipment that do not have a medicare rate established for a new purchase, MAA uses a pricing cluster to establish the rate.

(3) Establishing a pricing cluster and reimbursement rates.

(a) In order to make up a pricing cluster for a procedure code, MAA determines which brands/models of other DME its clients most frequently use. MAA obtains prices for these brands/models from manufacturer catalogs or commercial data bases. MAA may change or otherwise limit the number of brands/models included in the pricing cluster, based on the following:

(i) Client medical needs;

(ii) Product quality;

(iii) Introduction of new brands/models;

(iv) A manufacturer discontinuing or substituting a brand/model; and/or

(v) Cost.

(b) If a manufacturer list price is not available for any of the brands/models used in the pricing cluster, MAA calculates the reimbursement rate at the manufacturer's published cost to providers plus a thirty-five percent mark-up.

(c) For each brand used in the pricing cluster, MAA discounts the manufacturer's list price by twenty percent.

(i) If six or more brands/models are used in the pricing cluster, MAA calculates the reimbursement rate at the seventieth percentile of the pricing cluster.

(ii) If five brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the fourth highest discounted list price, as described in (b) of this subsection.

(iii) If four brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(iv) If three brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(v) If two or fewer brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the highest discounted list price, as described in (b) of this subsection.

(4) Rental reimbursement rates for other DME.

(a) MAA sets monthly rental rates at one-tenth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(b) MAA sets daily rental rates at one-three hundredth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(5) MAA annually evaluates and updates reimbursement rates for other DME.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2500, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2500, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2600 Prosthetics and orthotics. (1) MAA reimburses for prosthetics and orthotics to licensed prosthetic and orthotic providers only. This does not apply to:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out-of-state providers, who must meet the licensure requirements of that state.

(2) MAA does not cover prosthetics dispensed for purely cosmetic reasons.

(3) MAA covers a replacement prosthesis only when the purchase of a replacement prosthesis is less costly than repairing or modifying a client's current prosthesis.

(4) MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. MAA authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2700 Prosthetics and orthotics—Reimbursement. (1) MAA determines reimbursement for prosthetics and orthotics according to a set fee schedule. MAA considers medicare's current fee schedule when determining maximum allowable fees. For BR codes, MAA reimburses eighty-five percent of the agreed upon fee.

(2) MAA's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds.

(3) MAA's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

(4) MAA evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once per year, independent of scheduled legislatively authorized vendor rate increases. Rates remain effective until the next rate change.

(5) Reimbursement for prosthetics and orthotics is limited to HCPC/National Codes with the same level of coverage as medicare.

(6) Reimbursement for gender dyphoria surgery includes payment for all related prosthetics and supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2700, 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 nondurable 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.]

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) MAA determines rates for each category of medical supplies and non-DME (MSE) using either the:

(a) Medicare fee schedule; or

(b) Manufacturers' catalogs and commercial data bases for price comparisons.

(2) MAA evaluates and updates the maximum allowable fees for MSE as follows:

(a) MAA sets the maximum allowable fees for new MSE using one of the following:

(i) Medicare's fee schedule; or

(ii) For those items without a medicare fee, commercial data bases to identify brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:

(A) Eighty-five percent of the average manufacturer's list price; or

(B) One hundred twenty-five percent of the average dealer cost.

(b) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:

(i) A client's medical needs;

(ii) Product quality;

(iii) Cost; and

(iv) Available alternatives.

(3) MAA's nursing facility per diem rate includes any reusable and disposable medical supplies that may be required for a nursing facility client. MAA may reimburse the

following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

(i) Colostomy and other ostomy bags and necessary supplies; and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony; and

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(4) MAA considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2900, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2900, filed 12/13/00, effective 1/13/01.]

WAC 388-543-3000 DME and supplies provided in physician's office. MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the RBRVS, when it is appropriate.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-3000, filed 12/13/00, effective 1/13/01.]

Chapter 388-544 WAC
VISION AND HEARING AID SERVICES

WAC

VISION CARE

HEARING AID SERVICES

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-544-0200 Vision care services MAA covers without MAA's prior authorization. [Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0200, filed 12/6/00, effective 1/6/01.] Repealed by 05-13-038, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225.

388-544-0450 Vision care—Prior authorization. [Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-0450, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0450, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0450, filed 12/6/00, effective 1/6/01.] Repealed by 08-14-052, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520.

388-544-0475 Vision care—Noncovered services, eyeglasses, and contact lenses. [Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0475, filed 6/6/05, effective 7/7/05.] Repealed by 08-19-026, filed 9/8/08, effective 10/9/08. Statutory Authority: RCW 74.08.090. Later promulgation, see WAC 388-544-0575.

VISION CARE

WAC 388-544-0010 Vision care—General. (1) The department covers the vision care services listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter. The department pays for vision care when it is:

(a) Covered;

(b) Within the scope of the eligible client's medical care program;

(c) Medically necessary as defined in WAC 388-500-0005;

(d) Authorized, as required within this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda; and

(e) Billed according to this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda.

(2) The department does not require prior authorization for covered vision care services that meet the clinical criteria set forth in this chapter.

(3) The department requires prior authorization for covered vision care services when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process. The department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0010, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-0010, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0010, filed 6/6/05, effective 7/7/05.]

WAC 388-544-0050 Vision care—Definitions. The following definitions and those found in WAC 388-500-0005 apply to this chapter. Unless otherwise defined in this chapter, medical terms are used as commonly defined within the

scope of professional medical practice in the state of Washington.

"Blindness" - A diagnosis of visual acuity for distance vision of twenty/two hundred or worse in the better eye with best correction or a limitation of the client's visual field (widest diameter) subtending an angle of less than twenty degrees from central.

"Conventional soft contact lenses" or **"rigid gas permeable contact lenses" -** FDA-approved contact lenses that do not have a scheduled replacement (discard and replace with new contacts) plan. The soft lenses usually last one year, and the rigid gas permeable lenses usually last two years. Although some of these lenses are designed for extended wear, the department generally approves only those lenses that are designed to be worn as daily wear (remove at night).

"Disposable contact lenses" - FDA-approved contact lenses that have a planned replacement schedule (e.g., daily, every two weeks, monthly, quarterly). The contacts are then discarded and replaced with new ones as scheduled. Although many of these lenses are designed for extended wear, the department generally approves only those lenses that are designed to be worn as daily wear (remove at night).

"Expedited prior authorization" - A form of authorization used by the provider to certify that the department-published clinical criteria for a specific vision care service(s) have been met.

"Extended wear soft contacts" - Contact lenses that are designed to be worn for longer periods than daily wear (remove at night) lenses. These can be conventional soft contact lenses or disposable contact lenses designed to be worn for several days and nights before removal.

"Hardware" - Eyeglass frames and lenses and contact lenses.

"Prior authorization" - A form of authorization used by the provider to obtain the department's written approval for a specific vision care service(s). The department's approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.

"Specialty contact lens design" - Custom contact lenses that have a more complex design than a standard spherical lens. These specialty contact lenses (e.g., lenticular, aspheric, or myodisc) are designed for the treatment of specific disease processes, such as keratoconus, or are required due to high refractive errors. This definition of specialty contact lens does not include lenses used for surgical implantation.

"Stable visual condition" - A client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive correction is likely to be sufficient for one year or more.

"Visual field exams or testing" - A process to determine defects in the field of vision and test the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0050, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0050, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0100 Vision care—Eligible clients. (1) Vision care services are available to clients who are eligible for services under the following medical assistance programs only:

(a) Categorically needy program (CN or CNP);

(b) Categorically needy program - state children's health insurance program (CNP-SCHIP);

(c) Children's healthcare programs as defined in WAC 388-505-0210;

(d) Limited casualty program - medically needy program (LCP-MNP);

(e) General assistance (GA-U/ADATSA) (within Washington state or designated border cities); and

(f) Emergency medical only programs when the services are directly related to an emergency medical condition only.

(2) Clients who are enrolled in a department contracted managed care organization (MCO) are eligible under fee-for-service for covered vision care services that are not covered by their plan and subject to the provisions of this chapter and other applicable WAC.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0100, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0100, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0150 Vision care—Provider requirements. (1) Enrolled/contracted eye care providers must:

(a) Meet the requirements in chapter 388-502 WAC;

(b) Provide only those services that are within the scope of the provider's license;

(c) Obtain all hardware (including the tinting of eyeglass lenses) and contact lenses for clients from the department's designated supplier as published in the department's current vision care billing instructions; and

(d) Return all unclaimed hardware and contact lenses to the department's designated supplier using a postage-paid envelope furnished by the supplier.

(2) The following providers are eligible to enroll/contract with the department to provide and bill for vision care services furnished to eligible clients:

(a) Ophthalmologists;

(b) Optometrists;

(c) Opticians; and

(d) Ocularists.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0150, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0150, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0250 Vision care—Covered eye services (examinations, refractions, visual field testing, and vision therapy). (1) The department covers, without prior

authorization, eye examinations and refraction services with the following limitations:

(a) Once every twenty-four months for asymptomatic clients twenty-one years of age or older;

(b) Once every twelve months for asymptomatic clients twenty years of age or younger; or

(c) Once every twelve months, regardless of age, for asymptomatic clients of the division of developmental disabilities.

(2) The department covers additional examinations and refraction services outside the limitations described in subsection (1) of this section when:

(a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;

(b) The client is on medication that affects vision; or

(c) The service is necessary due to lost or broken eyeglasses/contacts. In this case:

(i) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.

(ii) Providers must follow the department's expedited prior authorization process to receive payment for clients twenty-one years of age or older. Providers must also document the following in the client's file:

(A) The eyeglasses or contacts are lost or broken; and

(B) The last examination was at least eighteen months ago.

(3) The department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

(4) The department covers orthoptics and vision training therapy. Providers must obtain prior authorization from the department.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0250, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0250, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0300 Vision care—Covered eyeglasses (frames and/or lenses) and repair services. (1) The department covers eyeglasses, without prior authorization, as follows:

(a) When the following clinical criteria are met:

(i) The client has a stable visual condition;

(ii) The client's treatment is stabilized;

(iii) The prescription is less than eighteen months old; and

(iv) One of the following minimum correction needs in at least one eye is documented in the client's file:

(A) Sphere power equal to, or greater than, plus or minus 0.50 diopter;

(B) Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or

(C) Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals.

(b) With the following limitations:

(i) Once every twenty-four months for clients twenty-one years of age or older;

(ii) Once every twelve months for clients twenty years of age or younger; or

(iii) Once every twelve months, regardless of age, for clients of the division of developmental disabilities.

(2) The department covers eyeglasses (frames/lenses), without prior authorization, for clients who are twenty years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this case, the limitations of subsection (1) of this section do not apply.

(3) The department covers one pair of back-up eyeglasses for clients who wear contact lenses as their primary visual correction aid (see WAC 388-544-0400(1)) with the following limitations:

(a) Once every six years for clients twenty years of age or older;

(b) Once every two years for clients twenty years of age or younger or regardless of age for clients of the division of developmental disabilities.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0300, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0300, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0325 Vision care—Covered eyeglass frames. (1) The department covers durable or flexible frames, without prior authorization, when the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a twelve-month period. To receive payment, the provider must:

(a) Follow the department's expedited prior authorization process; and

(b) Order the "durable" or "flexible" frames through the department's designated supplier.

(2) The department covers all of the following without prior authorization:

(a) Coating contract eyeglass frames to make the frames nonallergenic. Clients must have a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

(b) Incidental repairs to a client's eyeglass frames. To receive payment, all of the following must be met:

(i) The provider typically charges the general public for the repair or adjustment;

(ii) The contractor's one year warranty period has expired;

(iii) The cost of the repair does not exceed the department's cost for replacement frames and a fitting fee; and

(iv) The frequency of the repair does not exceed two per client in a six-month period. This limit does not apply to clients twenty years of age or younger or to clients of the division of developmental disabilities, regardless of age.

(3) The department covers replacement eyeglass frames that have been lost or broken as follows:

(a) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.

(b) To receive payment for clients twenty-one years of age or older, excluding clients of the division of developmental disabilities, providers must follow the department's expedited prior authorization process.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0325, filed 6/24/08, effective 7/25/08.]

WAC 388-544-0350 Vision care—Covered eyeglass lenses and services. (1) The department covers the following plastic scratch-resistant eyeglass lenses without prior authorization:

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Flat top trifocals; and

(d) Slab-off and prism lenses (including Fresnel lenses).

(2) Eyeglass lenses, as described in subsection (1) of this section must be placed into a frame that is, or was, purchased by the department.

(3) The department covers, without prior authorization, the following lenses when the clinical criteria are met:

(a) High index lenses. Providers must follow the department's expedited prior authorization process. The client's medical need in at least one eye must be diagnosed and documented as:

(i) A spherical refractive correction of plus or minus six diopters or greater; or

(ii) A cylinder correction of plus or minus three diopters or greater.

(b) Plastic photochromatic lenses. The client's medical need must be diagnosed and documented as ocular albinism or retinitis pigmentosa.

(c) Polycarbonate lenses. The client's medical need must be diagnosed and documented as one of the following:

(i) Blind in one eye and needs protection for the other eye, regardless of whether a vision correction is required;

(ii) Infants and toddlers with motor ataxia;

(iii) Strabismus or amblyopia for clients twenty years of age or younger; or

(iv) For clients of the division of developmental disabilities.

(d) Bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when:

(i) The client has attempted to adjust to the bifocals or trifocals for at least sixty days; and

(ii) The client is unable to make the adjustment; and

(iii) The trifocal lenses being replaced are returned to the provider.

(4) The department covers, without prior authorization, the tinting of plastic lenses when the client's medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than three months) eye conditions causing photophobia:

(a) Blindness;

(b) Chronic corneal keratitis;

(c) Chronic iritis, iridocyclitis;

(d) Diabetic retinopathy;

(e) Fixed pupil;

(f) Glare from cataracts;

(g) Macular degeneration;

(h) Migraine disorder;

(i) Ocular albinism;

(j) Optic atrophy and/or optic neuritis;

(k) Rare photo-induced epilepsy conditions; or

(l) Retinitis pigmentosa.

(5) The department covers replacement lenses when the lenses are lost or broken as follows:

(a) No type of authorization is required for clients twenty years of age and younger or for clients of the division of developmental disabilities, regardless of age.

(b) Providers must follow the expedited prior authorization process to receive payment for clients twenty-one years of age or older.

(6) The department covers replacement lenses, without prior authorization, when the client meets one of the clinical criteria. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

(a) Eye surgery or the effects of prescribed medication or one or more diseases affecting vision:

(i) The client has a stable visual condition;

(ii) The client's treatment is stabilized;

(iii) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and

(iv) The previous and new refraction are documented in the client's record.

(b) Headaches, blurred vision, or visual difficulty in school or at work. In this case, all of the following must be documented in the client's file:

(i) Copy of current prescription (less than eighteen months old);

(ii) Date of last dispensing, if known;

(iii) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); and

(iv) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0350, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, and 42 C.F.R. 440.120 and 440.225. 05-17-153, § 388-544-0350, filed 8/22/05, effective 9/22/05; 05-13-038, § 388-544-0350, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.-090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0400 Vision care—Covered contact lenses and services. (1) The department covers contact lenses, without prior authorization, as the client's primary refractive correction method when the client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. See subsection (4) of this section for exceptions to the plus or minus 6.0 diopter criteria. The spherical correction may be from the prescription for the glasses or the contact lenses and may be written in either "minus cyl" or "plus cyl" form.

(2) The department covers the following contact lenses with limitations:

(a) Conventional soft contact lenses or rigid gas permeable contact lenses that are prescribed for daily wear; or

(b) Disposable contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

(i) Twelve pairs of monthly replacement contact lenses; or

(ii) Four pairs of three-month replacement contact lenses.

(3) The department covers soft toric contact lenses, without prior authorization, for clients with astigmatism when the following clinical criteria are met:

(a) The client's cylinder correction is plus or minus 1.0 diopter in at least one eye; and

(b) The client meets the spherical correction listed in subsection (1) of this section.

(4) The department covers contact lenses, without prior authorization, when the following clinical criteria are met. In these cases, the limitations in subsection (1) of this section do not apply.

(a) For clients diagnosed with high anisometropia.

(i) The client's refractive error difference between the two eyes is at least plus or minus 3.0 diopters; and

(ii) Eyeglasses cannot reasonably correct the refractive errors.

(b) Specialty contact lens designs for clients who are diagnosed with one or more of the following:

(i) Aphakia;

(ii) Keratoconus; or

(iii) Corneal softening.

(c) Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

(5) The department covers replacement contact lenses, limited to once every twelve months, when lost or damaged as follows:

(a) Authorization is not required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.

(b) Providers must follow the expedited prior authorization process to receive payment for clients twenty-one years of age or older.

(6) The department covers replacement contact lenses when all of the clinical criteria are met:

(a) The clinical criteria are:

(i) One of the following caused the vision change:

(A) Eye surgery;

(B) The effect(s) of prescribed medication; or

(C) One or more diseases affecting vision.

(ii) The client has a stable visual condition;

(iii) The client's treatment is stabilized; and

(iv) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

(b) No type of authorization is required for clients twenty years of age and younger or for clients of the division of developmental disabilities, regardless of age.

(c) To receive payment for clients twenty-one years of age or older, providers must follow the expedited prior authorization process.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0400, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0400, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0500 Vision care—Covered ocular prosthetics. The department covers ocular prosthetics when provided by any of the following:

(1) An ophthalmologist;

(2) An ocularist; or

(3) An optometrist who specializes in prosthetics.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0500, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0500, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0550 Vision care—Covered eye surgery. (1) The department covers cataract surgery, without prior authorization, when the following clinical criteria are met:

(a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

(b) One or more of the following conditions:

(i) Dislocated or subluxated lens;

(ii) Intraocular foreign body;

(iii) Ocular trauma;

(iv) Phacogenic glaucoma;

(v) Phacogenic uveitis;

(vi) Phacoanaphylactic endopthalmitis; or

(vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.

(2) The department covers strabismus surgery as follows:

(a) For clients seventeen years of age and younger. The provider must clearly document the need in the client's record. The department does not require authorization for clients seventeen years of age and younger; and

(b) For clients eighteen years of age and older, when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

(i) The client has double vision; and

(ii) The surgery is not being performed for cosmetic reasons.

(3) The department covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the department's expedited prior authorization process. The clinical criteria are:

(a) The client's excess upper eyelid skin is blocking the superior visual field; and

(b) The blocked vision is within ten degrees of central fixation using a central visual field test.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0550, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0550, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0560 Vision care—Authorization. (1) The department requires providers to obtain authorization for covered vision care services as required in this chapter, chapters 388-501 and 388-502 WAC, and in published department billing instructions and/or numbered memoranda or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the department as specified in the department's published vision care billing instructions.

(b) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the department's published vision care billing instructions. The appropriate EPA number must be used when the provider bills the department.

(c) Upon request, a provider must provide documentation to the department showing how the client's condition met the criteria for PA or EPA.

(2) Authorization requirements in this chapter are not a denial of service.

(3) When a service requires authorization, the provider must properly request authorization in accordance with the department's rules, billing instructions, and numbered memoranda.

(4) When authorization is not properly requested, the department rejects and returns the request to the provider for further action. The department does not consider the rejection of the request to be a denial of service.

(5) The department's authorization of service(s) does not necessarily guarantee payment.

(6) The department evaluates requests for authorization of covered vision care services that exceed limitations in this chapter on a case-by-case basis in accordance with WAC 388-501-0169.

(7) The department may recoup any payment made to a provider if the department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100 (1)(c).

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0560, filed 6/24/08, effective 7/25/08.]

WAC 388-544-0575 Vision care—Noncovered services, eyeglasses, and contact lenses. (1) The department does not cover the following:

(a) Executive style eyeglass lenses;

(b) Bifocal contact lenses;

(c) Daily and two week disposable contact lenses;

(d) Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;

(e) Custom colored contact lenses;

(f) Services for cosmetic purposes only;

(g) Glass lenses;

(h) Group vision screening for eyeglasses;

(i) Nonglare or anti-reflective lenses;

(j) Progressive lenses;

(k) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections. This does not include intraocular lens implantation following cataract surgery.

(l) Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");

(m) Upgrades at private expense to avoid the department's contract limitations (e.g., frames that are not available through the department's contract or noncontract frames or lenses for which the client or other person pays the difference between the department's payment and the total cost).

(2) An exception to rule (ETR), as described in WAC 388-501-0160, may be requested for a noncovered service.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0575, filed 6/24/08, effective 7/25/08.]

WAC 388-544-0600 Vision care—Payment methodology. (1) To receive payment, vision care providers must bill the department according to the conditions of payment under WAC 388-502-0020 (1)(a) through (c) and WAC 388-502-0100 and the department's published billing instructions.

(2) The department pays one hundred percent of the department contract price for covered eyeglass frames, lenses, and contact lenses when these items are obtained through the department's approved contractor.

(3) See WAC 388-531-1850 for professional fee payment methodology.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520. 08-14-052, § 388-544-0600, filed 6/24/08, effective 7/25/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0600, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0600, filed 12/6/00, effective 1/6/01.]

HEARING AID SERVICES

WAC 388-544-1010 Definitions. "Expedited prior authorization" (EPA) means a process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

"FM systems" means a hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids.

"Limitation extension" (LE) means prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA billing instructions.

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Prior authorization" means MAA and/or department of health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1010, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1100 Hearing aid services—General. (1) The department covers only the hearing aid services listed in this chapter, subject to the exceptions, restrictions, and limitations listed in this chapter.

(2) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(3) The department evaluates requests for any service listed as noncovered in this chapter under the provisions in WAC 388-501-0160.

(4) The department reimburses providers at the maximum allowable rates established by the department.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1100, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1200 Hearing aid services—For adults. This section applies to medical assistance clients eighteen years of age or older:

(1) MAA covers the purchase of one new, nonrefurbished hearing aid for an adult client every five years if all of the following conditions are met:

(a) The client must be:

(i) Eighteen years of age or older; and

(ii) Eligible for the categorically needy program or the medical care services program.

(b) The client must either:

(i) Have an average hearing of fifty decibel hearing level (dBHL) in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispenser at one thousand, two thousand, three thousand, and four thousand Hertz (Hz) with effective masking as indicated; or

(ii) Be referred by a screening provider under the Healthy Kids/early and periodic screening, diagnosis, and treatment (EPSDT) program (only for clients eighteen to twenty years old).

(c) The client's current hearing aid, if the client has one, is not sufficient for the hearing loss in the better ear.

(d) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Initial one-year warranty has expired;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(d) Provider has documented the repair and replacement costs; and

(e) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired.

(5) MAA covers one replacement hearing aid in a five year period when the:

(a) Hearing aid is lost or broken beyond repair;

(b) Client continues to meet the criteria in subsection (1) of this section; and

(c) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of ear molds as follows:

(a) Once a year for soft ear molds; and

(b) Once every three years for hard ear molds.

(7) Prior MAA authorization is required for the following services for adults:

(a) Bone conduction hearing aids; and

(b) Binaural hearing aids.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1200, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1300 Hearing aid services—For children. This section applies to medical assistance clients seventeen years of age or younger:

(1) MAA covers the purchase of new, nonrefurbished hearing aids for children if all of the following conditions in subsections (1)(a) and (1)(b) are met:

(a) The child must:

(i) Be seventeen years of age or under;

(ii) Be eligible for any MAA medical program, except medically indigent program (MIP) and family planning only program; and

(iii) Have prior authorization from the child's local department of health's (DOH) children with special health care needs (CSHCN) coordinator to receive a hearing aid.

(b) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

(a) A prefitting evaluation;

(b) An ear mold for in-the-ear (ITE) hearing aids; and

(c) A minimum of three post-fitting consultations.

(3) MAA covers the repair of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the repair;

(b) Initial one-year warranty has expired;

(c) Client continues to meet the criteria in subsection (1) of this section;

(d) Cost of repair is less than fifty percent of the cost of a new hearing aid;

(e) Provider has documented the repair and replacement costs; and

(f) Repair is warranted for ninety days.

(4) MAA covers the cost of renting a hearing aid while the client's own hearing aid is being repaired when the rental is authorized for ninety days.

(5) MAA covers replacement of a hearing aid when the:

(a) Client's local CSHCN coordinator authorizes the replacement;

(b) Client continues to meet the criteria in subsection (1) of this section;

(c) Hearing aid is lost or broken beyond repair; and

(d) Provider has documented the necessity for the replacement.

(6) MAA covers replacement of hard and soft ear molds when the replacement is authorized by the client's local CSHCN coordinator.

(7) All hearing aid equipment and services for children require prior authorization from the client's local CSHCN coordinator, except FM systems which require prior authorization from MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1300, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1400 Hearing aid services—Noncovered services. (1) The department does not cover any of the following:

(a) The purchase of batteries, ear trumpets, or tinnitus maskers;

(b) Group screenings for hearing loss, except as provided under the Healthy Kids/EPSDT program under WAC 388-534-0100;

(c) Computer-aided hearing devices used in school;

(d) Hearing aid charges reimbursed by insurance or other payer source;

(e) Digital hearing aids; or

(f) FM systems or programmable hearing aids for:

(i) Adults;

(ii) Children when the device is used in school; or

(iii) Children whose hearing loss is adequately improved with hearing aids.

(2) The department evaluates a request for any service listed in this section as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-1400, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1400, filed 11/15/00, effective 12/16/00.]

Chapter 388-545 WAC
THERAPIES

WAC

WAC 388-545-300 Occupational therapy. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide occupational therapy services:

(a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following MAA programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 388-534 WAC; or

(ii) Receiving home health care services as described in chapter 388-551 WAC, subchapter II.

(3) Occupational therapy services received by MAA eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under chapter 388-551 WAC, subchapter II;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-550-2551;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-537-0100; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;

(ii) Assist a client in becoming employable;

(iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) MAA pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) MAA covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient

PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by MAA.

(6) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS), per client, per lifetime.

(7) MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

WAC 388-545-500 Physical therapy. (1) The following providers are eligible to provide physical therapy services:

(a) A licensed physical therapist or physiatrist; or

(b) A physical therapist assistant supervised by a licensed physical therapist.

(2) Clients in the following MAA programs are eligible to receive physical therapy services described in this chapter:

(a) Categorically needy (CN);

(b) Children's health;

(c) General assistance-unemployable (GA-U) (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program (MIP) for emergency hospital-based services only; or

(f) Medically needy program (MNP) only when the client is either:

(i) Twenty years of age or younger and referred under the early and periodic screening, diagnosis and treatment program (EPSDT/healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in chapter 388-551 WAC.

(3) Physical therapy services that MAA eligible clients receive must be provided as part of an outpatient treatment program:

(a) In an office, home, or outpatient hospital setting;

(b) By a home health agency as described in chapter 388-551 WAC;

(c) As part of the acute physical medicine and rehabilitation (acute PM&R) program as described in the acute PM&R subchapter under chapter 388-550 WAC;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or

(f) For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(4) MAA pays only for covered physical therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary and ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP);

(c) Begun within thirty days of the date ordered;

(d) For conditions which are the result of injuries and/or medically recognized diseases and defects; and

(e) Within accepted physical therapy standards.

(5) Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

(a) Prevent the need for hospitalization or nursing home care;

(b) Assist a client in becoming employable;

(c) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(d) Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(6) MAA determines physical therapy program units as follows:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(7) MAA does not limit coverage for physical therapy services listed in subsections (8) through (10) of this section if the client is twenty years of age or younger.

(8) MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients twenty-one years of age and older:

(a) One physical therapy evaluation. The evaluation is in addition to the forty-eight program units allowed per year;

(b) Forty-eight physical therapy program units;

(c) Ninety-six additional outpatient physical therapy program units when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement.

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(vi) Meningomyelocele;

(vii) Down's syndrome;

(viii) Cerebral palsy; or

(ix) Symptoms involving nervous and musculoskeletal systems and lack of coordination;

(d) Two durable medical equipment (DME) needs assessments. The assessments are in addition to the forty-eight physical therapy program units allowed per year. Two program units are allowed per DME needs assessment; and

(e) One wheelchair needs assessment in addition to the two durable medical needs assessments. The assessment is in addition to the forty-eight physical therapy program units allowed per year. Four program units are allowed per wheelchair needs assessment.

(f) The following services are allowed, per day, in addition to the forty-eight physical therapy program units allowed per year:

(i) Two program units for orthotics fitting and training of upper and/or lower extremities.

(ii) Two program units for checkout for orthotic/prosthetic use.

(iii) One muscle testing procedure. Muscle testing procedures cannot be billed in combination with each other.

(g) Ninety-six additional physical therapy program units are allowed following a completed and approved inpatient acute PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient physical therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of functions due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quadriplegics only;

(ix) Bilateral limb loss;

(x) Open wound of lower limb; or

(xi) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(9) For clients age twenty-one and older, MAA covers physical therapy services which exceed the limitations established in subsection (8) of this section if the provider requests prior authorization and MAA approves the request.

(10) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS) per client, per lifetime.

(11) Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).

(12) MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(13) MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be billed by the hospital.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.]

WAC 388-545-700 Speech/audiology services. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide, and be reimbursed for, speech/audiology services:

(a) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;

(b) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate;

(c) An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence; and

(d) School districts or educational service districts. Services must be noted in the client's individual educational program or individualized family service plan as described under WAC 388-537-0100.

(2) Clients in the following MAA programs are eligible to receive speech/audiology services described in this chapter:

(a) Categorically needy, children's health, general assistance unemployable, and Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) programs within Washington state or border areas only; or

(b) Medically needy program only when the client is either:

(i) Twenty years of age or under; or

(ii) Receiving home health care services as described under chapter 388-551 WAC, subchapter II;

(c) Medically indigent program only for emergency hospital-based services.

(3) MAA pays only for covered speech/audiology services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) For conditions which are the result of medically recognized diseases and defects; and

(c) Medically necessary, as determined by a health professional.

(4) The following speech/audiology services are covered per client, per calendar year, per provider:

(a) Unlimited speech/audiology program visits for clients twenty years of age and younger;

(b) One medical diagnostic evaluation for clients twenty-one years of age and older. The medical diagnostic evaluation is in addition to the twelve program visits allowed per year;

(c) One second medical diagnostic evaluation at the time of discharge for any of the following:

(i) Anoxic brain damage;

(ii) Acute, ill-defined, cerebrovascular disease;

(iii) Subarachnoid, subdural, and extradural hemorrhage following injury; or

(iv) Intracranial injury of other and unspecified nature;

(d) Twelve speech/audiology program visits for clients twenty-one years of age and older;

(e) Twenty-four additional speech/audiology visits if the speech/audiology service is for any of the following:

(i) Medically necessary conditions for developmentally delayed clients;

(ii) Neurofibromatosis;

(iii) Severe oral or motor dyspraxia;

(iv) Amyotrophic lateral sclerosis (ALS);

(v) Multiple sclerosis;

(vi) Cerebral palsy;

(vii) Quadriplegia;

(viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);

(ix) Acute, but ill-defined, cerebrovascular disease;

(x) Meningomyelocele;

(xi) Cleft palate and cleft lip;

(xii) Down's syndrome;

(xiii) Lack of coordination;

(xiv) Severe aphasia;

(xv) Severe dysphagia;

(xvi) Fracture of the:

(A) Vault or base of the skull;

(B) Multiple fracture involving skull or face with other bones;

(C) Cervical column;

(D) Larynx and trachea; or

(E) Other and unqualified skull fractures;

(xvii) Head injuries as follows:

(A) Cerebral laceration and contusion;

(B) Subarachnoid, subdural, and extradural hemorrhage following injury;

(C) Other and unspecified intracranial hemorrhage following injury;

(D) Injury to blood vessels of the head and neck; or

(E) Intracranial injury of other second unspecified nature;

(xvii) Burns of:

(A) The face, head, and neck, when severe;

(B) Multiple, specified sites; or

(C) Internal organs;

(xix) Cervical spinal cord injury without evidence of spinal bone injury; or

(xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional twenty-four visits for clients twenty-one years of age and older if approved by MAA.

(5) MAA limits:

(a) Caloric vestibular testing to four units for each ear, and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

(6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-545-700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

WAC 388-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed by the department;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, the department requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to the department;

(c) Sign a core provider agreement with the department; and

(d) Receive a neurodevelopmental center provider number from the department.

(3) Clients who are twenty years of age or younger and who meet the following eligibility criteria may receive covered services from neurodevelopmental centers:

(a) For occupational therapy, refer to WAC 388-545-300(2);

(b) For physical therapy, refer to WAC 388-545-500(2);

(c) For speech therapy and audiology services, refer to WAC 388-545-700(2); and

(d) For early and periodic screening, diagnosis and treatment (EPSDT) screening by physicians, refer to WAC 388-534-0100.

(4) The department reimburses neurodevelopmental centers for providing the following services to clients who meet the requirements in subsection (3) of this section:

(a) Occupational therapy services as described in WAC 388-545-300;

(b) Physical therapy services as described in WAC 388-545-500;

(c) Speech therapy and audiology services as described in WAC 388-545-700; and

(d) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in the department's billing instructions.

(5) In order to be reimbursed, neurodevelopmental centers must meet the department's billing requirements in WAC 388-502-0020, 388-502-0100 and 388-502-0150.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-545-900, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.09.080, 74.09.520 and 74.09.530. 01-20-114, § 388-545-900, filed 10/3/01, effective 11/3/01.]

Chapter 388-546 WAC
TRANSPORTATION SERVICES

WAC

WAC 388-546-0001 Definitions. The following definitions and abbreviations, and those found in WAC 388-500-0005, apply to this chapter unless otherwise specified.

"Advanced life support (ALS)" means that level of care that calls for invasive emergency medical services requiring advanced medical treatment skills.

"Advanced life support (ALS) assessment" means an assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service.

"Advanced life support (ALS) intervention" means a procedure that is beyond the scope of care of an emergency medical technician (EMT).

"Aid vehicle" means a vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedures.

"Air ambulance" means a helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service.

"Ambulance" means a ground or air vehicle designed and used to provide transportation to the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation; and licensed per RCW 18.73.140.

"Base rate" means the medical assistance administration's (MAA) minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage.

"Basic life support (BLS)" means that level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical procedures/services.

"Bed-confined" means the client is unable to perform all of the following actions:

(1) Get up from bed without assistance;

(2) Ambulate; and

(3) Sit in a chair or wheelchair.

"Bordering city hospital" means a licensed hospital in a designated bordering city (see WAC 388-501-0175).

"Broker" (see "transportation broker").

"Brokered transportation" means nonemergency transportation arranged by a broker, under contract with MAA, to or from covered medical services for an eligible client (also, see "transportation broker").

"By report" means a method of payment in which MAA determines the amount it will pay for a service that is covered but does not have an established maximum allowable fee. Providers must submit a report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Emergency medical service" means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting any client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

"Emergency medical transportation" means ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility.

"Ground ambulance" means a ground vehicle (including a water ambulance) designed and used to provide transportation to the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation.

"Invasive procedure" means a medical intervention that intrudes on the client's person or breaks the skin barrier.

"Lift-off fee" means either of the two base rates MAA pays to air ambulance providers for transporting a client. MAA establishes separate lift-off fees for helicopters and airplanes.

"Loaded mileage" means the number of miles the client is transported in the ambulance vehicle.

"Medical control" means the medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

"Nonemergency ambulance transportation" means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route, or the use of an air ambulance when prior authorized by MAA. Nonemergency ambulance transportation is usually scheduled or prearranged. See also "prone or supine transportation," and "scheduled transportation."

"Point of destination" means a facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved.

"Point of pickup" means the location of the client at the time he or she is placed on board the ambulance or transport vehicle.

"Prone or supine transportation" means transporting a client confined to a stretcher or gurney, with or without emergency medical services being provided en route.

"Scheduled transportation" means prearranged transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to or from a covered medical service.

"Specialty care transport (SCT)" means interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the paramedic.

"Standing order" means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or the ambulance provider's medical control.

"Transportation broker" means a person or organization contracted by MAA to arrange, coordinate and manage the provision of necessary but nonemergency transportation services for eligible clients to and from covered medical services.

"Trip" means transportation one-way from the point of pickup to the point of destination by an authorized transportation provider.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0001, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0001, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0100 The MAA ambulance transportation program. (1) The provisions of this chapter take precedence with respect to ambulance coverage in cases of ambiguity in, or conflict with, other rules governing eligibility for medical services.

(2) The medical assistance administration (MAA) covers medically necessary ambulance transportation to and from the provider of MAA covered services that is closest and most appropriate to meet the client's medical need. See WAC 388-546-0150 through 388-546-4000 for ambulance transportation and WAC 388-546-5000 through 388-546-5600 for brokered/nonemergency transportation.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0100, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0100, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0150 Client eligibility for ambulance transportation. (1) Except for clients in the Family Planning Only program, MAA fee-for-service clients are eligible for ambulance transportation to MAA covered services with the following limitations:

(a) Clients in the following programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 388-501-0175:

(i) General assistance-unemployable (GA-U);

(ii) General assistance-expedited medical (GA-X);

(iii) General assistance-pregnancy (GA-S);

(iv) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA);

(v) Emergency medical programs, including alien emergency medical (AEM);

(vi) LCP-MNP emergency medical only; and

(vii) State Children's Health Insurance Program (CHIP) when the client is not enrolled in a managed care plan.

(b) Clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 388-546-0400(5).

(2) Clients enrolled in an MAA managed care plan receive all ambulance services through their designated plan, subject to the plan's coverages and limitations.

(3) Clients enrolled in MAA's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with MAA requirements. MAA pays for covered services for these clients according to MAA's published billing instructions.

(4) Clients under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to individuals who are being detained involuntarily for mental health treatment and being transported to or from bordering cities. See also WAC 388-546-4000.

(5) See WAC 388-546-0800 and 388-546-2500 for additional limitations on out-of-state coverage and coverage for clients with other insurance.

(6) Jail inmates and persons living in a correctional facility are not eligible for MAA ambulance coverage. See WAC 388-503-0505(5).

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0150, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0150, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0200 Scope of coverage for ambulance transportation. (1) The ambulance program is a medical transportation service. The medical assistance administration (MAA) pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see WAC 388-501-0060);

(b) Medically necessary as defined in WAC 388-500-0005 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The nearest appropriate MAA-contracted medical provider of MAA-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) MAA limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can

safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ambulance service is not covered by MAA. See WAC 388-546-0250 (1) and (2) for noncovered ambulance services.

(3) If medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, MAA requires the provider when billing MAA for that trip to:

(a) Report the third party determination on the claim; and

(b) Submit documentation showing that the trip meets the medical necessity criteria of MAA. See WAC 388-546-1000 and 388-546-1500 for requirements for nonemergency ambulance coverage.

(4) MAA covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when MAA determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the air ambulance transportation must be prior authorized by MAA. See WAC 388-546-1500 for nonemergency air ambulance coverage.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-546-0200, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0200, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0200, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0250 Ambulance services the department does not cover. (1) The department does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 388-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC 388-546-4000(2));

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC 388-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the department does not cover the ambulance service, except as provided in WAC 388-546-0500(2).

(3) The department evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the department evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The department approves such requests when medically necessary, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 388-502-0160 are met.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-546-0250, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0250, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0250, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0300 General requirements for ambulance providers. (1) Ambulances must be licensed, operated, and equipped according to federal, state, and local statutes, ordinances and regulations.

(2) Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and 18.73.170.

(3) The medical assistance administration (MAA) requires providers of ambulance services to document medical justification for transportation and related services billed to MAA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of the transportation. MAA may review the client record to ensure MAA's criteria were met.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0300, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0300, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0400 General limitations on payment for ambulance services. (1) In accordance with WAC 388-502-0100(8), the medical assistance administration (MAA) pays providers the lesser of the provider's usual and customary charges or the maximum allowable rate established by MAA. MAA's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) MAA does not pay providers under fee-for-service for ambulance services provided to a client who is enrolled in an MAA managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.

(3) MAA does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. MAA pays for loaded mileage only as follows:

(a) MAA pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) MAA pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

(4) MAA does not pay for ambulance services if:

(a) The client is not transported;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 388-546-0500(2)).

(5) For clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs MAA's payment is as follows:

(a) If medicare covers the service, MAA will pay the lesser of:

(i) The full coinsurance and deductible amounts due, based upon medicaid's allowed amount; or

(ii) MAA's maximum allowable for that service minus the amount paid by medicare.

(b) If medicare does not cover or denies ambulance services that MAA covers according to this chapter, MAA pays at MAA's maximum allowable; except MAA does not pay for clients on the qualified medicare beneficiaries (QMB) only program.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0400, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0400, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0425 Ambulance coverage during inpatient hospitals stays. (1) The medical assistance administration (MAA) does not cover ambulance transportation services under fee-for-service when a client remains as an inpatient client in a hospital and the transportation to and/or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such services is the responsibility of the hospital, whether MAA pays the hospital under the diagnosis-related group (DRG) or ratio of costs-to-charges (RCC) method.

(2) Except as provided in subsections (3) and (5) of this section, MAA does not cover hospital to hospital transfers of clients under fee-for-service when ambulance transportation is requested solely to:

(a) Accommodate a physician's or other health care provider's preference for facilities;

(b) Move the client closer to family or home (i.e., for personal convenience); or

(c) Meet insurance requirements or hospital/insurance agreements.

(3) MAA covers under fee-for-service ambulance transportation for a client being transferred from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required by the client. MAA covers air ambulance transportation for hospital transfers only if transportation by ground ambulance would endanger the client's life or health. The reason for transferring a client from one hospital to another, as well as the need for air ambulance transport, if applicable, must be clearly documented in the client's hospital chart and in the ambulance trip report.

(4) MAA does not cover under fee-for-service ambulance transportation for a client being transferred from a hospital providing a higher level of care to a hospital providing a lower level of care, except as allowed under subsection (5) of this section.

(5) MAA considers requests for fee-for-service ambulance coverage under the provisions of WAC 388-501-0160 (exception to rule) for transportation of a client from an intervening hospital to the discharging hospital. MAA evaluates such requests based on clinical considerations and cost-effectiveness. MAA's decision under the provisions of WAC 388-501-0160 is final. The reason for transferring a client from a hospital to another medical facility must be clearly documented in the client's hospital chart and in the ambulance trip record.

(6) Specialty care transport (SCT) is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. MAA pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport, provided:

(a) The criteria for covered hospital transfers under fee-for-service are met; and

(b) There is a written reimbursement agreement between the ambulance provider and SCT personnel. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, MAA pays the provider at the basic life support (BLS) rate.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0425, filed 8/17/04, effective 9/17/04.]

WAC 388-546-0450 Payment for ground ambulance services. (1) The medical assistance administration (MAA) pays for two levels of service for ground ambulance transportation: Basic life support (BLS) and advanced life support (ALS):

(a) A BLS ambulance trip is one in which the client requires and receives basic medical services at the scene and/or en route from the scene of the acute and emergent illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are: Controlling bleeding, splinting fracture(s), treating for shock, and performing cardiopulmonary resuscitation (CPR).

(b) An ALS trip is one in which the client requires and receives more complex services at the scene and/or en route from the scene of the acute and emergent illness or injury to a hospital. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle as defined by chapter 18.83 RCW. Examples of complex medical services or ALS procedures are:

(i) Administration of medication by intravenous push/bolus or by continuous infusion;

(ii) Airway intubation;

(iii) Cardiac pacing;

(iv) Chemical restraint;

(v) Chest decompression;

(vi) Creation of surgical airway;

(vii) Initiation of intravenous therapy;

(viii) Manual defibrillation/cardioversion;

(ix) Placement of central venous line; and

(x) Placement of intraosseous line.

(2) MAA pays for ambulance services (BLS or ALS) based on the client's actual medical condition and the level of medical services needed and provided during the trip.

(a) Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify a trip for MAA payment at the ALS level of service unless ALS services were provided.

(b) A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided en route.

(c) An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client en route to the treatment facility.

(3) MAA's base rate includes: Necessary personnel and services; oxygen and oxygen administration; intravenous supplies and IV administration reusable supplies, disposable supplies, required equipment, and waiting time. MAA does not pay separately for chargeable items/services that are provided to the client based on standing orders.

(4) MAA pays ground ambulance providers the same mileage rate, regardless of the level of service. Ground ambulance mileage is paid when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

(5) MAA pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. Acceptable reasons for allowable extra mileage include, but are not limited to:

(a) A hospital was on "divert" status and not accepting patients; or

(b) A construction site caused a detour, or had to be avoided to save time.

(6) When multiple ambulance providers respond to an emergency call, MAA pays only the ambulance provider that actually furnishes the transportation.

(7) MAA pays for an extra attendant, when the ground ambulance provider documents in the client's file the justification for the extra attendant, and that the extra attendant is on-board for the trip because of one or more of the following:

(a) The client weighs three hundred pounds or more;

(b) The client is violent or difficult to move safely;

(c) The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained during the trip; or

(d) More than one client is being transported, and each requires medical attention and/or close monitoring.

(8) MAA pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting MAA clients. To be paid, providers must document the toll(s) by attaching the receipt(s) for the toll(s) to the claim.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0450, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0450, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0500 Payment for ground ambulance services in special circumstances. (1) When more than one client is transported in the same ground ambulance at the same time, the provider must bill the medical assistance administration (MAA):

(a) At a reduced base rate for the additional client, and

(b) No mileage charge for the additional client.

(2) MAA pays an ambulance provider at the appropriate base rate (BLS or ALS) if no transportation takes place because the client died at the scene of the illness or injury but the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. See WAC 388-546-0450(1) for examples of medical interventions associated with each base rate. The intervention(s)/supplies provided must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies at the scene of the illness or injury after medical interventions/supplies are provided but before transport takes place.

(3) In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets MAA's fee schedule definition of an ALS intervention, the BLS provider may bill MAA the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists. The provider must give MAA a copy of the agreement upon request. If there is no written agreement between the BLS and ALS entities, MAA will pay only for the BLS level of service.

(4) In areas that distinguish between residents and nonresidents, MAA must be billed the same rate for ambulance services provided to a client in a particular jurisdiction as would be billed by that provider to the general public in the same jurisdiction.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0500, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0500, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0600 Procedure code modifiers. Ambulance providers must use procedure code modifiers published by MAA when billing MAA for ambulance trips. The appropriate modifiers must be used for all services related to the same trip for the same client.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0600, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0600, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0700 Payment limitations for air ambulance services. (1) MAA pays for air ambulance services only when all of the following apply:

(a) The necessary medical treatment is not available locally or the client's point of pick up is not accessible by ground ambulance;

(b) The vehicle and crew meet the provider requirements in WAC 388-546-0300 and 388-546-0800;

(c) The client's destination is an acute care hospital; and

(d) The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance; or

(e) The client's physical or medical condition is such that traveling on a commercial flight is not safe.

(2) MAA pays providers for one lift-off fee per client, per trip.

(3) Air mileage is based on loaded miles flown, as expressed in statute miles.

(4) Except as provided in WAC 388-546-0800(6), MAA pays for extra air mileage with sufficient justification. The reason for the added mileage must be documented in the client's record and the ambulance trip report. Acceptable reasons include, but are not limited to:

(a) Having to avoid a "no fly zone"; or

(b) Being forced to land at an alternate destination due to severe weather.

(5) MAA pays a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number of clients transported and bill MAA for the mileage portion attributable to each eligible client.

(6) If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, MAA limits its payment as follows:

(a) If air ambulance is used and the trip involves more than one lift off, MAA pays only one lift-off fee per client and the total of air miles. If an air ambulance transport for the same client involves both rotary and fixed wing aircraft, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.

(b) If both air and ground ambulances are used, MAA pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided in WAC 388-546-0800(6).

(7) MAA does not pay separately for individual services or an extra attendant for air ambulance transportation. MAA's lift-off fee and mileage payment includes all personnel, services, supplies, and equipment related to the transport.

(8) MAA does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has MAA's prior authorization for the transportation services and fees. If authorized, MAA's payment is based on the actual cost to provide the service or at MAA's established rates, whichever is lower. MAA does not pay separately for items or services that MAA includes in the established rate(s).

(9) If MAA determines, upon review, that an air ambulance trip was not:

(a) Medically necessary, MAA may deny or recoup its payment and/or limit payment based on MAA's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or

(b) To the nearest available and appropriate hospital, MAA may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.

(10) Providers must have prior authorization from MAA for any nonemergency air transportation, whether by air ambulance or other mode of air transportation. Nonemergency air transportation includes scheduled transports to or from out-of-state treatment facilities.

(11) MAA uses commercial airline companies (i.e., MAA does not authorize air ambulance transports) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.

(12) MAA does not pay for air ambulance services if no transportation is provided.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0700, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0700, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0800 Payment for ambulance services provided in another state or U.S. territory. (1) The department pays for emergency ambulance transportation provided to eligible Washington state fee-for-service medical assistance clients who are in another state or U.S. territory when the emergency medical situation occurs according to the provisions of WAC 388-501-0180, 388-501-0182, and 388-502-0120.

(2) To receive payment from the department, an out-of-state ambulance provider must:

(a) Meet the licensing requirements of the ambulance provider's home state or province; and

(b) Have a signed agreement with the department.

(3) The department pays for emergency ambulance transportation provided out of state for an eligible Washington state medical assistance client under fee-for-service when the transport is:

(a) Within the scope of the client's medical care program;

(b) Medically necessary as defined in WAC 388-500-0005; and

(c) To the nearest appropriate treatment facility.

(4) The department does not pay for an ambulance transport provided in another state for a fee-for-service Washington state medical assistance client when:

(a) The client's medical eligibility program covers medical services within Washington state and/or designated bordering cities only. See WAC 388-546-0150 and 388-546-0200(5);

(b) The ambulance transport was nonemergent and was not prior authorized by the department.

(5) The department pays for emergency ambulance transportation at the lower of:

(a) The provider's billed amount; or

(b) The rate established by the department.

(6) To receive payment from the department for a nonemergency transport, an ambulance provider, who transports a Washington state medical assistance client to a facility that is out of state or brings a client into the state from a location that is out of state, must obtain prior authorization from the department.

(7) The department pays a negotiated rate for a medically necessary nonemergency interstate ambulance transport that the department has prior authorized. The ambulance provider is responsible for ensuring that all medical services necessary for the client's safety during the transport are available onboard the vehicle or aircraft. The contractual amount for a nonemergency air ambulance transport may include:

(a) The cost of medically necessary ground ambulance transport from the discharging facility to the point-of-pickup (airstrip); and

(b) The cost of medically necessary ground ambulance transport from the landing point (airstrip) to the receiving facility.

(8) The department does not pay to transport clients under the involuntary treatment act (ITA) program to or from locations outside the state of Washington. For ITA purposes, transports to or from designated bordering cities are not covered. See WAC 388-546-4000.

(9) The department requires out-of-state ground ambulance providers who transport a Washington state medical assistance client into, within, or outside the state of Washington, to comply with RCW 18.73.180 regarding stretcher transportation.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-546-0800, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0800, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0800, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0900 Ambulance coverage in Canada, Mexico, and other countries. The department does not cover ambulance transportation for eligible medical assistance clients traveling outside of the United States and U.S. territories. See WAC 388-501-0184 for ambulance coverage in British Columbia, Canada.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-546-0900, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0900, filed 8/17/04, effective 9/17/04.]

WAC 388-546-1000 Coverage for nonemergency ground ambulance transportation. (1) The medical assistance administration (MAA) pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

(a) The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or

(b) The client's medical condition requires that he or she have basic ambulance level medical attention available during transportation, regardless of bed confinement.

(2) MAA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation as follows:

(a) For nonemergency, scheduled ambulance services that are repetitive in nature, the ambulance provider must obtain a written physician certification statement (PCS) from the client's attending physician certifying that the ambulance services are medically necessary. The PCS must specify the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services. The PCS must be dated no earlier than sixty days before the first date of service. A PCS for repetitive, nonemergency ambulance services is valid for sixty days as long as the client's medical condition does not improve. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.

(b) For nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider must obtain from the client's attending physician a signed PCS within forty-eight hours after the transport. The PCS must certify that the ambulance services are medically necessary.

(c) If the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed certificate of medical necessity form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has personal knowledge of the client's medical condition at the time the ambulance service was furnished. In lieu of the attending physician, one of the following may sign the certification form: a physician assistant, a nurse practitioner, a registered nurse, a clinical nurse specialist, or a hospital discharge planner. The signed certificate must be obtained from the alternate provider no later than twenty-one calendar days from the date of service.

(d) If, after twenty-one days, the ambulance provider is unable to obtain the signed PCS from the attending physician or alternate provider for nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider may submit a claim to MAA, as long as the provider is able to show acceptable documentation of the attempts to obtain the PCS.

(e) In addition to the signed certification statement of medical necessity, all other program criteria must be met in order for MAA to pay for the service.

(3) Ground ambulance providers may choose to enter into contracts with MAA's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs MAA would incur under subsection (1) of this section.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-1000, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-1000, filed 1/16/01, effective 2/16/01.]

WAC 388-546-1500 Coverage for nonemergency air ambulance transportation. (1) The medical assistance administration (MAA) pays for a nonemergency air ambulance transport only when the transport is prior authorized by MAA.

(2) MAA authorizes a nonemergency air ambulance transport only when the following conditions are met:

(a) The client's destination is an acute care hospital or approved rehabilitation facility; and

(b) The client's physical or medical condition is such that travel by any other means endangers the client's health; or

(c) Air ambulance is less costly than ground ambulance under the circumstances.

(3) MAA requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical justification must be submitted to MAA prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-1500, filed 8/17/04, effective 9/17/04.]

WAC 388-546-2500 Transportation to or from out-of-state treatment facilities—Coordination of benefits. (1) The medical assistance administration (MAA) does not pay for a client's transportation to or from an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

(2) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

(a) Denies the client's request for medical services out-of-state for lack of medical necessity; or

(b) Denies the client's request for transportation for lack of medical necessity.

(3) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not consider requests for transportation to or from out-of-state treatment facilities unless the client has tried all of the following:

(a) Requested coverage of the benefit from his/her primary insurer and been denied;

(b) Appealed the denial of coverage by the primary insurer; and

(c) Exhausted his/her administrative remedies through the primary insurer.

(4) If MAA authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, MAA's liability is limited to the cost of the least costly means of transportation that does not jeopardize the client's health, as determined by MAA in consultation with the client's referring physician.

(5) For clients eligible for out-of-state coverage but have other third-party insurance, MAA considers requests for transportation to or from out-of-state treatment facilities under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-2500, filed 8/17/04, effective 9/17/04.]

WAC 388-546-3000 Transporting qualified trauma cases. (1) The medical assistance administration (MAA) does not pay ambulance providers an additional amount for transports involving qualified trauma cases described in WAC 388-550-5450.

(2) Ambulance providers may apply to the department of health (DOH) for possible grants related to transports of qualified trauma cases.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-3000, filed 8/17/04, effective 9/17/04.]

WAC 388-546-4000 Transportation coverage under the Involuntary Treatment Act (ITA). (1) For purposes of this section, the following definitions apply:

(a) "Nearest and most appropriate destination" means the nearest facility able and willing to accept the involuntarily detained individual for treatment, not the closest facility based solely on driving distance.

(b) "County-designated mental health professional (CD-MHP)" means a person who, under the guidelines specified by the Involuntary Treatment Act (ITA):

(i) Assesses a client's level of need for transportation according to procedures established by the county in which the client being assessed resides; and

(ii) Decides, following the assessment, how a client should be transported to an inpatient psychiatric treatment facility.

(c) "Involuntary Treatment Act" means, for adults, chapter 71.05 RCW; for juveniles, chapter 71.34 RCW. See also chapter 388-865 WAC.

(d) "Regional support network (RSN)" means a county authority or group of county authorities recognized by the secretary of the department of social and health services (DSHS) and which contracts with DSHS to implement a locally managed community mental health program.

(2) The medical assistance administration (MAA) covers transportation under ITA for an individual who is being involuntarily detained for mental health treatment, after that individual has been assessed by a CD-MHP and found to be:

(a) A danger to self;

(b) A danger to others; or

(c) Gravely disabled.

(3) Transportation under ITA may be provided to an eligible individual by an organization designated as an ITA provider by the local community mental health center and/or RSN. Designated ITA providers must comply with the department's requirements for drivers, driver training, vehicle and equipment standards and maintenance.

(4) Transportation under the ITA for an individual described in subsection (2) is covered from:

(a) The site of the initial detention;

(b) An evaluation and treatment facility designated by the department; or

(c) A court hearing.

(5) Transportation under the ITA for an individual described in subsection (2) is covered when provided to:

(a) An evaluation and treatment facility;

(b) A less restrictive alternative setting, except when ambulance transport to a client's home is not covered; or

(c) A court hearing.

(6) The CD-MHP authorizes the level of transportation provided under ITA to and from covered facilities based on the individual's need. A copy of the authorization by the CD-MHP must be kept in the individual's file.

(7) MAA pays for ITA transports to the nearest and most appropriate destination. The reason for the diversion to a more distant facility must be clearly documented in the individual's file.

(8) The department's mental health division (MHD) establishes payment for ITA transports. Providers must clearly identify ITA transports on the claim form when submitting claims to MAA.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-4000, filed 8/17/04, effective 9/17/04.]

WAC 388-546-5000 Nonemergency transportation program definitions. The following terms apply to WAC 388-546-5000, 388-546-5100, 388-546-5200, 388-546-5300, 388-546-5400, and 388-546-5500:

"Broker" means an organization or entity contracted with the department of social and health services (DSHS)/ **medical assistance administration (MAA)** to arrange nonemergency transportation services for MAA's clients.

"Drop off point" means the place authorized by the transportation broker for the client's trip to end.

"Escort" means a person authorized by the broker to be transported with a client to a medical service. An escort may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.

"Guardian" means a person who is legally responsible for a client and who may be required to be present when a client is receiving medical services.

"Local provider of type" means the medical provider within the client's local community who fulfills the requirements of the medical appointment. The provider may vary by medical specialty, the provider's acceptance of MAA's clients, and whether managed care, primary care case management or third party participation is involved.

"Noncompliance" means a client:

(1) Engages in violent, seriously disruptive, or illegal conduct;

(2) Poses a direct threat to the health and/or safety of self or others; or

(3) Fails to be present at the pickup point of the trip.

"Pickup point" means the place authorized by MAA's transportation broker for the client's trip to begin.

"Return trip" means the return of the client to the client's home, or another authorized return point, from the location where a covered medical service has occurred.

"Service mode" means the method of transportation the transportation broker selects to use for an MAA client.

"Stretcher trip" means a transportation service that requires a client to be transported in a prone or supine position. This may be by stretcher, board or gurney (reclined and with feet elevated). Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

"Trip" means transportation one-way from the **pickup point** to the **drop off point** by an authorized transportation provider.

"Urgent care" means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5000, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5100 Nonemergency transportation program scope of coverage. (1) The department's health and recovery services administration (HRSA) covers transportation that is necessary for its clients to receive **medically necessary** HRSA covered services. See WAC 388-546-0100 through 388-546-1000 for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with HRSA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC 388-546-5200 as administrative services.

(3) HRSA covers nonemergency transportation under WAC 388-546-5000 through 388-546-5500 as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (**service mode**).

(4) Prior authorization by HRSA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.

(a) HRSA reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC 388-501-0180, 388-501-0182 and 388-501-0184.

(b) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC 388-501-0184.

(5) HRSA requires all nonemergency transportation to and from covered services to meet the following:

(a) The covered service must be medically necessary as defined in WAC 388-500-0005;

(b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and

(c) Be limited to the **local provider of type** as follows:

(i) Clients receiving services provided under HRSA's fee-for-service program may be transported only to the local provider of type. HRSA's transportation **broker** is responsible for considering and authorizing exceptions.

(ii) Clients enrolled in HRSA's managed care (healthy options) program may be transported to any **provider** supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.

(6) HRSA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by HRSA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC 388-546-5400(1).

(7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.

(8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.

(9) HRSA does not cover any nonemergency transportation service that is not addressed in WAC 388-546-1000 or in 388-546-5000 through 388-546-5500. See WAC 388-501-0160 for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).

(10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.

(11) HRSA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where HRSA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5000 through 388-546-5400, tribal members obtain their transportation services as provided by the tribe or tribal agency.

(12) A client who is denied service under this chapter may request a fair hearing per chapter 388-02 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.035. 08-08-064, § 388-546-5100, filed 3/31/08, effective 5/1/08. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5100, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5200 Nonemergency transportation program broker and provider requirements. (1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC 388-546-5100(2).

(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.

(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized **trip**.

(4) MAA's transportation brokers must comply with the terms specified in their contracts.

(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC 388-546-5300(2)) with the exception of hospital requests or **urgent care** trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.

(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:

(a) Documented as to the reasons retroactive authorization is needed; and

(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.

(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:

(a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));

(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));

(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);

(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100 (1) and (5)(a));

(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or

(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.

(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5200, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5300 Nonemergency transportation program client requirements. (1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in **noncompliance** may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.

(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200 (5) and (6).

(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.

(4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:

(a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;

(b) The client's service is covered by a **third party** payer and the payer requires or refers the client to a specific provider;

(c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;

(d) The medical service required by the client is not available within the local healthcare service area;

(e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or

(f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:

(i) Documented by the client's primary care provider; and

(ii) Agreed to by MAA's contracted transportation broker.

(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.

(6) If local medical services are not available to a client because of **noncompliance** with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5300, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5400 Nonemergency transportation program general reimbursement limitations. (1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC 388-546-5100(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:

(a) When there is medical justification for a shorter trip;

(b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or

(c) When the trip involves an area that the broker determines is not physically accessible to the client.

(2) MAA reimburses for **return trips** from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.

(3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.

(4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:

(a) Transportation to and from an immediate subsequent medical referral; or

(b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.

(5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).

(6) MAA may pay transportation costs, including meals and lodging, for authorized **escorts.** MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).

(7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.

(8) MAA may reimburse for the transportation of a **guardian** with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5400, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5500 Modifications of privately owned vehicles. (1) MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:

(a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and

(b) The client owns a vehicle that MAA determines is suitable for modification; and

(c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and

(d) Prior approval from MAA is obtained.

(2) Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.

(3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection (1) of this section are met.

(4) MAA must remain the payer of last resort under this section.

(5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5500, filed 3/2/01, effective 4/2/01.]

Chapter 388-549 WAC
RURAL HEALTH CLINICS

WAC

WAC 388-549-1000 Rural health clinics—Purpose. This chapter establishes the department's reimbursement methodology for rural health clinic (RHC) services. RHC conditions for certification are found in 42 CFR part 491.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1000, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1100 Rural health clinics—Definitions. This section contains definitions of words and phrases that apply to this chapter. Unless defined in this chapter or WAC 388-500-0005, the definitions found in the Webster's New World Dictionary apply.

"Base year"—The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

"Change in scope of service"—A change in the type, intensity, duration, or amount of service.

"Encounter"—A face-to-face visit between a client and a qualified rural health clinic (RHC) provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

"Encounter rate"—A cost-based, facility-specific rate for covered RHC services, paid to a rural health clinic for each valid encounter it bills.

"Enhancements" (also called healthy options (HO) enhancement)—A monthly amount paid to RHCs for each client enrolled with a managed care organization (MCO). Plans may contract with RHCs to provide services under healthy options. RHCs receive enhancements from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

"Fee-for-service"—A payment method the department uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter rate.

"Interim rate"—The rate established by the department to pay a rural health clinic for covered RHC services prior to the establishment of a prospective payment system (PPS) rate for that facility.

"Medicare cost report"—The cost report is a statement of costs and provider utilization that occurred during the time period covered by the cost report. RHCs must complete and submit a report annually to medicare.

"Mobile unit"—The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

"Permanent unit"—The objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic are housed in a permanent structure.

"Rural area"—An area that is not delineated as an urbanized area by the Bureau of the Consensus.

"Rural health clinic (RHC)"—A clinic, as defined in 42 CFR 405.2401(b), that is primarily engaged in providing RHC services and is:

- Located in a rural area designated as a shortage area as defined under 42 CFR 491.2;
- Certified by medicare as a RHC in accordance with applicable federal requirements; and
- Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural health clinic (RHC) services"—Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic and the like, including specified types of diagnostic examination, laboratory services, and emergency treatments. The specific list of services which must be made available by the clinic can be found under 42 CFR part 491.9.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1100, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1200 Rural health clinics—Enrollment. (1) To participate in the Title XIX (medicaid) program and receive payment for services, a rural health clinic (RHC) must:

(a) Receive RHC certification for participation in the Title XVIII (medicare) program according to 42 CFR 491;

(b) Sign a core provider agreement;

(c) Comply with the clinical laboratory improvement amendments (CLIA) of 1988 testing for all laboratory sites per 42 CFR part 493; and

(d) Operate in accordance with applicable federal, state, and local laws.

(2) An RHC may be a permanent or mobile unit. If an entity owns clinics in multiple locations, each individual site must be certified by the department in order to receive reimbursement from the department as an RHC.

(3) The department uses one of two timeliness standards for determining the effective date of a medicaid-certified RHC.

(a) The department uses medicare's effective date if the RHC returns a properly completed core provider agreement and RHC enrollment packet within sixty days from the date of medicare's letter notifying the clinic of the medicare certification.

(b) The department uses the date the signed core provider agreement is received if the RHC returns the properly completed core provider agreement and RHC enrollment packet after sixty days of the date of medicare's letter notifying the clinic of the medicare certification.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1200, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1300 Rural health clinics—Services. (1) Rural health clinic (RHC) services are defined under 42 CFR 440.20(b).

(2) The department pays for RHC services when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060; and

(b) Medically necessary as defined in WAC 388-500-0005.

(3) RHC services may be provided by any of the following individuals in accordance with 42 CFR 405.2401:

(a) Physicians;

(b) Physician assistants (PA);

(c) Nurse practitioners (NP);

(d) Nurse midwives or other specialized nurse practitioners;

(e) Certified nurse midwives;

(f) Registered nurses or licensed practical nurses; and

(g) Psychologists or clinical social workers.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1300, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1400 Rural health clinics—Reimbursement and limitations. (1) For rural health clinics (RHC) certified by medicare on and after January 1, 2001, the department pays RHCs an encounter rate per client, per day using a prospective payment system (PPS) as required by 42 USC 1396a(bb) for RHC services.

(a) The department calculates the RHC's encounter rate for RHC core services as follows:

(i) Until the RHC's first audited medicare cost report is available, the department pays an average encounter rate of other similar RHCs (such as hospital-based or free-standing) within the state, otherwise known as an interim rate.

(ii) Upon availability of the RHC's audited medicare cost report, the department sets the clinic's encounter rate at one hundred percent of its costs as defined in the cost report. The RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary services.

(2) For RHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the clinic's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-549-1500.

(b) The PPS base encounter rates are determined using medicare's audited cost reports and each year's rate is weighted by the total reported encounters. The department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

$$\text{Base Encounter Rate} = \frac{(1999\ \text{Rate} \times 1999\ \text{Encounters}) + (2000\ \text{Rate} \times 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})}$$

(c) Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the MEI and adjusted for any increase or decrease in the clinic's scope of services.

(3) The department pays for one encounter, per client, per day except in the following circumstances:

(a) The visits occur with different doctors with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(4) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(5) Services other than RHC services that are provided in an RHC are not included in the RHC encounter rate. Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the department's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 388-557 WAC.

(6) For clients enrolled with a managed care organization, covered RHC services are paid for by that plan.

(7) The department does not pay the encounter rate or the enhancements for clients in state-only programs. Services provided to clients in state-only programs are considered fee-for-service, regardless of the type of service performed.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1400, filed 2/7/08, effective 3/9/08.]

WAC 388-549-1500 Rural health clinics—Change in scope of service. (1) The department considers a rural health clinic's (RHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the RHC. Changes in scope of service apply only to covered medicaid services.

(2) When the department determines that a change in scope of service has occurred after the base year, the department will adjust the RHC's perspective payment system (PPS) rate to reflect the change.

(3) RHCs must:

(a) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty days after the effective date of the change; and

(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(4) The department adjusts the PPS rate to reflect the change in scope of service using one or more of the following:

(a) A medicaid comprehensive desk review of the RHC's cost report;

(b) Review of a medicare audit of the RHC's cost report; or

(c) Other documentation relevant to the change in scope of service.

(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1500, filed 2/7/08, effective 3/9/08.]

Chapter 388-550 WAC
HOSPITAL SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-550-1750 Services requiring approval. [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, § 388-550-1750, filed 12/18/97, effective 1/18/98.] Repealed by 04-20-058, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 74.09.500.

388-550-2000 Medical criteria—Transplant services. [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, § 388-550-2000, filed 12/18/97, effective 1/18/98.] Repealed by 07-14-055, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 74.09.500.

388-550-2300 Payment—PM&R. [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, § 388-550-2300, filed 12/18/97, effective 1/18/98.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.

388-550-2700 Substance abuse detoxification services. [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, § 388-550-2700, filed 12/18/97, effective 1/18/98.] Repealed by 01-16-142, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652.

388-550-3401 How MAA pays acute PM&R facilities for Level B services. [Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3401, filed 8/18/99, effective 9/18/99.] Repealed by 03-06-047, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56.

388-550-5100 Payment method—MIDSH. [Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5100, 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, § 388-550-5100, 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, § 388-550-5100, 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, § 388-550-5100, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.-090.

388-550-5250 Payment method—THAPDSH. [Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5250, 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, § 388-550-5250, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

388-550-5300 Payment method—STHFPDSH. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.-290. 02-21-019, § 388-550-5300, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5300, 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, § 388-550-5300, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

388-550-5350 Payment method—CTHFPDSH. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.-290. 02-21-019, § 388-550-5350, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5350, 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, § 388-550-5350, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

388-550-5900 Prior authorization—Outpatient services. [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, § 388-550-5900, filed 12/18/97, effective 1/18/98.] Repealed by 04-20-058, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 74.09.500.

388-550-6800 Proportionate share payments for inpatient hospital services. [Statutory Authority: RCW 74.04.050, 74.08.-090. 05-12-132, § 388-550-6800, 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, § 388-550-6800, filed 6/12/03, effective 7/13/03.] Repealed by 06-08-046, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500.

388-550-6900 Proportionate share payments for outpatient hospital services. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-6900, filed 6/12/03, effective 7/13/03.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

WAC 388-550-1000 Applicability. The department pays for hospital services provided to eligible clients when:

(1) The eligible client is a patient in an acute care hospital and the hospital meets the definition of hospital or psychiatric hospital in RCW 70.41.020, WAC 388-500-0005 or 388-550-1050;

(2) The services are medically necessary as defined under WAC 388-500-0005; and

(3) The conditions, exceptions and limitations in this chapter are met.

[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 healthcare 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 non-medical 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.

["]Inpatient 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 healthcare 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.

"Spenddown" 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 techni-

cian'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 payment 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 on 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 department 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," "angiocardiography," "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 speciality 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 categories 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," "che-

motherapy - 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," "electromyelogram," "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 postpayment 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 criteria 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 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 388-550-2431 Hospice services—Inpatient payments. See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

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 388-550-2551 How a client qualifies for acute PM&R services. (1) To qualify for acute PM&R services, a client must meet one of the conditions in subsection (2) of this section and have:

(a) Extensive or complex medical needs, nursing needs, and therapy needs; and

(b) A recent or new onset of a condition that causes an impairment in two or more of the following areas:

(i) Mobility and strength;

(ii) Self-care/ADLs (activities of daily living);

(iii) Communication; or

(iv) Cognitive/perceptual functioning.

(2) To qualify for acute PM&R services, a client must meet the conditions in subsection (1) of this section and have a new or recent onset of one of the following conditions:

(a) Brain injury caused by trauma or disease.

(b) Spinal cord injury resulting in:

(i) Quadriplegia; or

(ii) Paraplegia.

(c) Extensive burns.

(d) Bilateral limb loss.

(e) Stroke or aneurysm with resulting hemiplegia or cognitive deficits, including speech and swallowing deficits.

(f) Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits.

(g) Severe pressure ulcers after skin flap surgery for a client who:

(i) Requires close observation by a surgeon; and

(ii) Is ready to mobilize or be upright in a chair.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2551, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2551, 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 long-term acute care (LTAC) program.

"Level 1 services" means long-term acute care (LTAC) services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one of the following:

(1) Ventilator weaning care; or

(2) Care for a client who has:

(a) Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and

(b) At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

"Level 2 services" means long-term acute care (LTAC) services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

(1) Ventilator care for a client who is ventilator-dependent and is not weanable and has complex medical needs; or

(2) Care for a client who:

(a) Has a tracheostomy;

(b) Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and

(c) Has at least one comorbid condition (such as quadriplegia).

"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.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 08-21-039, § 388-550-2570, filed 10/8/08, effective 11/8/08; 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 long-term acute care (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 in the letter required under (a) of this subsection, documentation that confirms the hospital is:

(i) Medicare-certified for LTAC;

(ii) Accredited by the joint commission on accreditation of healthcare organizations (JCAHO);

(iii) Licensed as an acute care hospital by the department of health (DOH) under chapter 246-320 WAC (if an in-state hospital), or by the state in which the hospital is located (if an out-of-state hospital); and

(iv) Enrolled with the department as a medicaid participating provider.

(2) A 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 recommended approval of the hospital's request for LTAC designation; and

(c) The department provides written notification to the hospital that it qualifies for payment when providing LTAC services to eligible medical assistance clients.

(3) Department-approved LTAC hospitals must meet the general requirements in chapter 388-502 WAC.

(4) The department may, in its sole discretion, approve a hospital located in Idaho or Oregon that is not in a designated bordering city as an LTAC hospital if:

(a) The hospital meets the requirements of this section; and

(b) The hospital provider signs a contract with the department agreeing to the payment rates established for LTAC services in accordance with WAC 388-550-2595.

(5) The department does not have any legal obligation to approve any hospital or other entity as an LTAC hospital.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 08-21-039, § 388-550-2580, filed 10/8/08, effective 11/8/08; 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 long term acute care (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; 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 admitting the client to the LTAC hospital, submit a request for prior authorization to the department 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) Obtain prior authorization from the department's medical director or designee, when accepting the client from the transferring hospital; and

(D) Meet all the requirements in WAC 388-550-2580.

(b) For any extension of stay, the criteria in (a) of this subsection must be met, and the LTAC provider of services must submit a request for the extension of stay to the department with sufficient medical justification.

(2) The department 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.

(3) 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.

(4) The department may authorize an administrative day rate payment for a client who meets one or more of the following. The client:

(a) Does not meet the requirements for Level 1 or Level 2 LTAC services;

(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 and 74.09.500. 08-21-039, § 388-550-2590, filed 10/8/08, effective 11/8/08; 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 limited 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 costs 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid and non-SCHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid 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 nonmedicaid 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 nonmedicaid base community psychiatric hospitalization payment rate applies only to a nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid 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 nonmedicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650 in conjunction with the nonmedicaid 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 nonmedicaid [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 388-550-2750 Hospital discharge planning services. For discharge planning service requirements, see chapter 246-318 WAC.

[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, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

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.
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.
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.

Payment method used for medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
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.
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 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 388-550-2900 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 rela-

tive 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 nonmedicaid relative weights. The department:

(i) May combine the medicaid-specific relative weights with the nonmedicaid relative weights if the nonmedicaid relative weights are statistically comparable to the medicaid-specific weights; or

(ii) Uses only the medicaid-specific relative weights if the nonmedicaid 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 conversion 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 accommoation 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) data base, 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 CBCF 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 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 instate 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 adust 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 char-

acteristic 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 instate 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 instate 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 instate hospitals approved by the department to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all instate 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 instate hospitals approved by the department to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the instate 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 instate statewide bariatric operating payment per case, the instate 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 instate 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 $500	The greater amount of 3 x app. DRG pymt ($15,000) or $33,000
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 noncovered 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:

$N = (Z^2 * S^2)/R^2$, 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 classification 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 noncovered 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 nonpediatric 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 Are Greater 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:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$95,600 x 65% = $62,140 = Department determined estimated costs

[3]If 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 x 85% = $9,924 = High outlier portion allowed amount

[4]Base 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:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 65% = $41,925 = Department determined estimated costs

[3]If 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.

[4]Base 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:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$77,000 x 65% = $50,050 = Department determined estimated costs

[3]If 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)) x 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.

[4]Base 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:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 (rate) x 25 (days) = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$100,000 x 70% = $70,000 = Department determined estimated costs

[3]If 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) x 85% = $22,313 = High outlier portion allowed amount

[4]Base 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:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 25 = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 70% = $45,150 = Department determined estimated costs

[3]If 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.

[4]Base 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):

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 35 = $35,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$75,000 x 70% = $52,500 = Department determined estimated costs

[3]If 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 tan $0, otherwise $0.

($52,500 - $61,250 = (8,750)) x 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.

[4]Base 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 instate 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 instate 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 instate 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 instate 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 instate 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 instate 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 instate 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 instate 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 instate 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 instate 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 department-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 388-550-4650 "Full cost" public hospital certified public expenditure (CPE) payment program. (1) The department's "full cost" public hospital certified public expenditure (CPE) payment program provides payments to participating hospitals based on the "full cost" of covered medically necessary services and requires the expenditure of local funds in lieu of state funds to qualify for federal matching funds. The department's payments to participating hospitals equal the federal matching amount for allowable costs. The department uses the ratio of costs-to-charges method described in WAC 388-550-4500 to determine "full cost."

(2) Only the following facilities are reimbursed through the "full cost" public hospital CPE payment program:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; 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.

(3) Payments made under the CPE payment program are limited to medically necessary services provided to medical assistance clients eligible for inpatient hospital services.

(4) Each hospital described in subsection (2) of this section is responsible to provide certified public expenditures as the required state match for claiming federal medicaid funds.

(5) The department determines the actual payment for inpatient hospital services under the CPE payment program by:

(a) Multiplying the hospital's medicaid RCC rate by the covered charges (to determine allowable costs), then;

(b) Subtracting the client's responsibility and any third party liability (TPL) from the amount derived in (a) of this subsection, then;

(c) Multiplying the state's federal matching assistance percentage (FMAP) by the amount derived in (b) of this subsection.

[Statutory Authority: RCW 74.08.090, 74.09.500. 06-08-046, § 388-550-4650, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-4650, filed 6/1/05, effective 7/1/05.]

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 provision and subject to legislative directives and appropriations, 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. All hospital submissions pertaining to the CPE payment program, including but not limited to cost report schedules, are subject to audit at any time by the department or its designee.

(1) The department:

(a) Uses historical cost and payment data trended forward to calculate prospective hold harmless grant payment amounts for the current state fiscal year (SFY); and

(b) Reconciles these hold harmless grant payment amounts when the actual claims data is available for the current fiscal year.

(2) 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; or

(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.

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(3) For each SFY, the department determines total state and federal payments made under the program, including:

(a) Inpatient claim payments;

(b) Disproportionate share hospital (DSH) payments; and

(c) Supplemental upper payment limit payments made for SFY 2006 and 2007, as applicable.

(4) The amount determined in subsection (3) of this section is subtracted from the amount calculated in subsection (2) of this section to determine the gross state grant amount necessary to hold the hospital harmless. If the resulting number is positive, the hospital is entitled to a grant in that amount, subject to legislative directives and appropriations.

(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. Prospective grant payments made under subsection (1) of this section are deducted from the calculated interim hold harmless grant amount to determine the net grant payment amount due to or due from the hospital.

(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 utili-

zation review and audit prior to the final calculation of the hold harmless amount. Interim grant payments determined under (a) of this subsection are deducted from this final calculation to determine the net final hold harmless amount due to or due from the hospital.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 08-20-032, § 388-550-4670, filed 9/22/08, effective 10/23/08; 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 388-550-4690 Authorization requirements and utilization review for hospitals eligible for CPE payments. This section does not apply to psychiatric certified public expenditure (CPE) inpatient hospital admissions. See WAC 388-550-2600.

(1) CPE inpatient hospital claims submitted to the department must meet all authorization and program requirements in WAC and current department-published issuances.

(2) The department performs utilization reviews of inpatient hospital:

(a) Admissions in accordance with the requirements of 42 CFR 456, subparts A through C; and

(b) Claims for compliance with medical necessity, appropriate level of care and the department's (or a department designee's) established length of stay (LOS) standards.

(3) For CPE inpatient admissions prior to August 1, 2007, the department performs utilization reviews:

(a) Using the professional activity study (PAS) length of stay (LOS) standard in WAC 388-550-4300 on claims that qualified for ratio of costs-to-charges (RCC) payment prior to July 1, 2005.

(b) On seven-day readmissions according to the diagnosis related group (DRG) payment method described in WAC 388-550-3000 (5)(f) for claims that qualified for DRG payment prior to July 1, 2005.

(4) For claims identified in this subsection, the department may request a copy of the client's hospital medical records and itemized billing statements. The department sends written notification to the hospital detailing the department's findings. Any day of a client's hospital stay that exceeds the LOS standard:

(a) Is paid under a nonDRG payment method if the department determines it to be medically necessary for the client at the acute level of care;

(b) Is paid as an administrative day (see WAC 388-550-1050 and 388-550-4500(8)) if the department determines it to be medically necessary for the client at the subacute level of care; and

(c) Is not eligible for payment if the department determines it was not medically necessary.

(5) For CPE inpatient admissions on and after August 1, 2007, CPE hospital claims are subject to the same utilization review rules as nonCPE hospital claims.

(a) LOS reviews may be performed under WAC 388-550-4300.

(b) All claims are subject to the department's medical necessity review under WAC 388-550-1700(2).

(c) For inpatient hospital claims that involve a client's seven-day readmission, see WAC 388-550-3000 (5)(f).

[Statutory Authority: RCW 74.08.090 and 74.09.500. 08-20-032, § 388-550-4690, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9). 06-11-100, § 388-550-4690, 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:

County	Community Travel Distance Standard
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

County	Community Travel Distance Standard
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 nonemergent 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 Add-on Amount	(+)	*DRG Allowed Amount
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 instate-average ratable and an instate-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 Unstable Neonate DRGs	RCC RCC	Per diem Per diem
Psych	RCC	Per diem
Rehab	RCC	Per diem
Detox	RCC	Per diem
Transplant	RCC	RCC
Military hospitals	RCC	RCC
HIV Chronic pain management	RCC Per diem	Not separately defined 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 instate and critical border hospitals, the hospital's specific DRG conversion factor that is used to calculate payment 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 instate 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 instate 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 payment. 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 nonneonatal DRGs and nonpediatric 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 following specialty service categories and unstable DRG nonspecialty 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 instate 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 nonmedicaid 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 nonmedicaid 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 instate 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 instate 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 instate 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 (SRIADSH) program. (1) The department makes small rural indigent assistance disproportionate share hospital (SRIADSH) 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 SRIADSH 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 CPE medicaid cost report and settlements. (1) For patients discharged on or after July 1, 2005, 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. The cost report schedules for uninsured patients must not include services that medicaid would not have covered had the patients been medicaid eligible (see WAC 388-550-1400 and 388-550-1500); 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) 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 calendar 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 calendar days after the medicare cost report is due to its medicare fiscal intermediary or medicare administrative contractor, whichever is applicable.

(b) Complete the cost report schedules for uninsured patients and medicaid clients enrolled in an MCO plan using the hospital provider's records.

(c) Comply with the department's instructions regarding how to complete the required medicaid cost report schedules.

(3) The medicaid cost report schedules must be completed using the medicare cost report for the same reporting year.

(a) The ratios of costs-to-charges and per diem costs from the "as filed" medicare cost report are used to allocate the medicaid and uninsured costs on the "as filed" medicaid cost report schedules, unless expressly allowed for medicaid.

(b) After the medicare cost report is finalized by the medicare fiscal intermediary or medicare administrative contractor (whichever is applicable), final medicaid cost report schedules must be submitted to the department incorporating the adjustments to the medicare cost report, unless expressly allowed for medicaid. CPE hospitals must submit finalized medicare cost reports with the notice of amount of program reimbursement (NPR) within thirty calendar days of receipt. The department will then provide the hospitals with updated PS&R reports for medicaid and state program claims processed by the department for the medicaid cost report period. The hospitals will update the data for uninsured patients and medicaid clients enrolled in an MCO plan.

(4) The medicaid cost report schedules and supporting documentation are subject to audit by the department or its designee to verify that claimed costs qualify under federal and state rules governing the CPE payment program. The documentation required includes, but is not limited to:

(a) The revenue codes assigned to specific cost centers on the medicaid cost report schedules.

(b) The inpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(c) The outpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(d) All payments received for the inpatient and outpatient charges in (b) and (c) of this subsection including, but not limited to, payments for third party liability, uninsured patients, and medicaid clients enrolled in an MCO plan.

(5) The department:

(a) Performs cost settlements for both the "as filed" and "final" medicaid cost report schedules for all CPE hospitals;

(b) Reports to CMS as an adjustment any difference between the payments of federal funds made to the CPE hospitals and the federal share of the certified public expenditures; and

(c) Recoups from the CPE hospitals the federal payments that exceed the hospitals' costs, unless the hold harmless provision in WAC 388-550-4670 is applicable.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 08-20-032, § 388-550-5410, filed 9/22/08, effective 10/23/08; 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 payment 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 qualifying payment percentage for the service year-to-date is multiplied by the available amount for the service year-to-date, and then the department subtracts what has been allocated to each hospital for the service year-to-date to determine the portion of the current quarterly payment pool to be paid to each qualifying hospital. This method for determining supplemental distributions to hospitals applies to TCF allotments beginning with state fiscal year (SFY) 2008. This method supersedes and preempts the method adopted in rule and effective August 1, 2007. 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 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 designated 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 as specified in WAC 388-502-0150(3). 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, 74.09.160, 74.09.500, and 70.168.040. 08-08-065, § 388-550-5450, filed 3/31/08, effective 5/1/08. 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 388-550-5500 Payment—Hospital-based RHCs. (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The department shall determine the hospital-based rural health clinic's RCC from the hospital's annual medicare cost report, pursuant to WAC 388-550-4500(1).

[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, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5550 Public notice for changes in medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe the manner in which the department, pertaining to medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department is proposing or implementing a medicaid rate change based on a change in medicaid rate setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the department.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the department's internet home page on the worldwide web: http://www.wa.gov/dshs/maa is the internet address.

(3) The department will notify stakeholders of proposed and final changes in individual medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates; and

(c) Publish the final medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the department will determine the manner of publication of proposed or final medicaid hospital rates.

(b) Publication of proposed medicaid hospital rates will occur as follows:

(i) The department will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the department will post proposed rates on the department's web site.

(c) Publication of final medicaid hospital rates will occur as follows:

(i) The department will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final medicaid hospital rates or proposed and final amendments to WAC 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such stakeholders postage prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to medicare rules, methods, or levels of reimbursement for clients who are eligible for both medicare and medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rulemaking is necessary to implement the change; or

(iii) Part of a nonmedicaid program.

(b) Although notice and publication are not required for medicaid rate changes described in subsection (7)(a) of this section, the department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department and an individual hospital negotiate or contractually agree to medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final medicaid contract rates are effective on the date contractually agreed to by the department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the department in proposing or implementing a change to medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the department; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the department under which hospital providers may appeal their medicaid rates.

[Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

WAC 388-550-5600 Dispute resolution process for hospital rate reimbursement. The dispute resolution process for hospital rate reimbursement follows the procedures as stated in WAC 388-502-0220.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5600, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. 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, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5700 Hospital reports and audits. (1) In-state and border area hospitals shall complete and submit a copy of their annual medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual medicare HCFA 2552 cost report according to the applicable medicare statutes, regulations, and instructions; and

(c) Submit a copy to the department:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days prior to the due date of the report. Hospital providers shall include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[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, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5800 Outpatient and emergency hospital services. The department shall cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[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, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

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 388-550-6100 Outpatient hospital physical therapy. (1) The department pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 388-545-500 and 388-550-6000.

(2) A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6100, 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, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6150 Outpatient hospital occupational therapy. (1) The department pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 388-545-300 and 388-550-6000.

(2) The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6150, 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, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6200 Outpatient hospital speech therapy services. (1) The department pays for speech therapy services provided to eligible clients as an outpatient hospital service according to this section and WAC 388-545-700 and 388-550-6000.

(2) The department requires swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(3) The department requires a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(4) A hospital must bill outpatient hospital speech therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay the outpatient hospital a facility fee for these services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6200, 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, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6250 Pregnancy—Enhanced outpatient benefits. The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[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, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6300 Outpatient nutritional counseling. (1) The department shall cover nutritional counseling services only for eligible medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[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, § 388-550-6300, 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 388-550-6400 Outpatient hospital diabetes education. (1) The department pays for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility where the services are provided is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The department requires the diabetes education teaching curriculum to have measurable, behaviorally stated educational objectives. The diabetes education teaching curriculum must include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the women, infants, and children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long-term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin startup.

(3) The department pays for a maximum of six hours of individual core survival skills outpatient diabetes education per calendar year per client.

(4) The department requires DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue code(s) designated and published by the department.

(5) The department reimburses for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6400, 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, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6450 Outpatient hospital weight loss program. The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[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, § 388-550-6450, 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 388-550-6600 Hospital-based physician services. See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[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, § 388-550-6600, 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 instate hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. Department designated critical border hospitals are paid as instate 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 pro-

vider 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 OPPS.

"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 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 OPPS—Exempt hospitals. The department exempts the following hospitals from the initial implementation of department's outpatient prospective payment system (OPPS). (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 OPPS.)

(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 OPPS—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 (OPPS).

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 OPPS. 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.

OPPS 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 OPPS—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 OPPS 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 adjustor is established. See WAC 388-550-7050 for the definition of budget target adjustor.

[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 OPPS conversion factor. The department calculates the outpatient prospective payment system (OPPS) 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 OPPS 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 OPPS 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 OPPS conversion factor x Discount factor (if applicable) x Units of service (if applicable) x

Budget target adjustor

(2) The total OPPS 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 388-551 WAC
ALTERNATIVES TO HOSPITAL SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-551-1315 Example of how hospice client certifications (election periods) work. [Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1315, filed 4/9/99, effective 5/10/99.] Repealed by 05-18-033, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.08.090, 74.09.520.

388-551-1410 Hospice providers must notify institutional providers. [Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1410, filed 4/9/99, effective 5/10/99.] Repealed by 05-18-033, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.08.090, 74.09.520.

SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

WAC 388-551-1000 Hospice program—General. (1) The department's hospice program is a twenty-four hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care rather than cure. A hospice interdisciplinary team communicates with the client's nonhospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

(2) A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must certify the client as terminally ill and appropriate for hospice care.

(3) Hospice care is provided in a client's temporary or permanent place of residence.

(4) Hospice care ends when:

(a) The client or an authorized representative under RCW 7.70.065 revokes the hospice care;

(b) The hospice agency discharges the client;

(c) The client's physician determines hospice care is no longer appropriate; or

(d) The client dies.

(5) Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

(6) Department-approved hospice agencies must meet the general requirements in chapter 388-502 WAC, Administration of medical programs—Providers.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1000, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1010 Hospice program—Definitions. The following definitions and abbreviations and those found

in WAC 388-500-0005, Medical definitions, apply to this subchapter.

"Authorized representative" means an individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065.

"Biologicals" means medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" means six days or less within a thirty consecutive-day period.

"Community services office (CSO)" means an office of the department that administers social and health services at the community level.

"Discharge" means an agency ends hospice care for a client.

"Election period" means the time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care.

"Family" means an individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client.

"Home and community services (HCS) office" means an aging and disability services administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities.

"Home health aide" means an individual registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related activities, or both, to patients of a hospice agency, or hospice care center.

"Home health aide services" means services provided by home health aides employed by an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, and personal care or homemaker services, and other nonmedical tasks, as defined in this section.

"Hospice agency" means a person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer. (Note: For the purposes of this subchapter, requirements for hospice agencies also apply to hospice care centers.)

"Hospice care center" means a homelike noninstitutional facility where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280 and applicable rules.

"Hospice services" means symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.

"Interdisciplinary team" means the group of individuals involved in client care providing hospice services or hospice care center services including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer.

"Palliative" means medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care" means a written document based on assessment of client needs that identifies services to meet these needs.

"Related condition(s)" means any health conditions(s) that manifests secondary to or exacerbates symptoms associated with the progression of the condition and/or disease, the treatment being received, or the process of dying. (Examples of related conditions: Medication management of nausea and vomiting secondary to pain medication; skin breakdown prevention/treatment due to peripheral edema.)

"Residence" means a client's home or place of living.

"Revoke" or **"revocation"** means the choice to stop receiving hospice care.

"Terminally ill" means the client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" means a day beginning and ending at midnight.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1010, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

Hospice—Coverage

WAC 388-551-1200 Client eligibility for hospice care. (1) A client who elects to receive hospice care must be eligible for one of the following medical assistance programs, subject to the restrictions and limitations in this chapter and other WAC:

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP);

(c) Children's health (V);

(d) State children's health insurance program (SCHIP);

(e) CNP—Alien emergency medical;

(f) LCP-MNP—Alien emergency medical; or

(g) General assistance-expedited disability (GAX).

(2) A hospice agency is responsible to verify a client's eligibility with the client or the client's home and community services (HCS) office or community services office (CSO).

(3) A client enrolled in one of the department's managed care plans must receive all hospice services, including facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing all hospice services for a client enrolled in a managed care plan.

(4) A client who is also eligible for medicare part A is not eligible for hospice care through the department's hospice program. The department does pay hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center (HCC) and is not

receiving general inpatient care or inpatient respite care. See also WAC 388-551-1530.

(5) A client who meets the requirements in this section is eligible to receive hospice care through the department's hospice program when all of the following is met:

(a) The client's physician certifies the client has a life expectancy of six months or less.

(b) The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 388-551-1310.

(c) The hospice agency serving the client:

(i) Notifies the department's hospice program within five working days of the admission of all clients, including:

(A) Medicaid-only clients;

(B) Medicaid-medicare dual eligible clients;

(C) Medicaid clients with third party insurance; and

(D) Medicaid-medicare dual eligible clients with third party insurance.

(ii) Meets the hospice agency requirements in WAC 388-551-1300 and 388-551-1305.

(d) The hospice agency provides additional information for a diagnosis when the department requests and determines, on a case-by-case basis, the information that is needed for further review.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1200, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate. (1) The department reimburses a hospice agency for providing covered services, including core services and supplies described in this section, through the department's hospice daily rate, subject to the conditions and limitations described in this section and other WAC.

(2) To qualify for reimbursement, covered services, including core services and supplies in the hospice daily rate, must be:

(a) Related to the client's hospice diagnosis;

(b) Identified by the client's hospice interdisciplinary team;

(c) Written in the client's plan of care (POC); and

(d) Made available to the client by the hospice agency on a twenty-four hour basis.

(3) The hospice daily rate includes the following core services that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

(a) Physician services related to the administration of POC.

(b) Nursing care provided by:

(i) A registered nurse (RN); or

(ii) A licensed practical nurse (LPN) under the supervision of an RN.

(c) Medical social services provided by a social worker under the direction of a physician.

(d) Counseling services provided to a client and the client's family members or caregivers.

(4) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

(a) Assure all contracted staff meets the regulatory qualification requirements;

(b) Have a written agreement with the service organization or individual providing the services and supplies; and

(c) Maintain professional, financial, and administrative responsibility.

(5) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC 388-551-1510(6), subject to the conditions and limitations described in this section and other WAC:

(a) Skilled nursing care;

(b) Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions;

(c) Communication with nonhospice providers about care not related to the client's terminal illness to ensure the client's plan of care needs are met and not compromised;

(d) Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions;

(e) Home health aide, homemaker, and/or personal care services that are ordered by a client's physician and documented in the POC. (Home health aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services. See 42 CFR 484.36);

(f) Physical therapy, occupational therapy, and speech-language therapy to manage symptoms or enable a client to safely perform ADLs (activities of daily living) and basic functional skills;

(g) Medical transportation services;

(h) A brief period of inpatient care, for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility; and

(i) Other services or supplies that are documented as necessary for the palliation and management of a client's terminal illness and related conditions;

(6) A hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the hospice program. The department does not pay separately for medical equipment or supplies that were previously authorized by the department and delivered on or after the date the department enrolls the client in the hospice program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1210, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

Hospice—Provider Requirements

WAC 388-551-1300 Requirements for a department-approved hospice agency. (1) To become a department-approved hospice agency, the department requires a hospice agency to provide documentation that it is medicare, Title

XVIII certified by the department of health (DOH) as a hospice agency.

(2) A department-approved hospice agency must at all times meet the requirements in chapter 388-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) To ensure quality of care for medical assistance client's, the department's clinical staff may conduct hospice agency site visits.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1300, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1305 Requirements for becoming a department-approved hospice care center (HCC). (1) To apply to become a department-approved hospice care center, the department requires a hospice agency to:

(a) Be enrolled with the department as a department hospice agency (see WAC 388-551-1300);

(b) Submit a letter of request to:

Hospice Program Manager
Division of Medical Management
Department of Social and Health Services
PO Box 45506
Olympia, WA 98504-5506; and

(c) Include documentation that confirms the agency is medicare certified by department of health (DOH) as a hospice care center and provides one or more of the following levels of hospice care (levels of care are described in WAC 388-551-1500):

(i) Routine home care;

(ii) Inpatient respite care; and

(iii) General inpatient care.

(2) A department-approved hospice care center must at all times meet the requirements in chapter 388-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) A hospice agency qualifies as a department-approved hospice care center when:

(a) All the requirements in this section are met; and

(b) The department provides the hospice agency with written notification.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1305, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1310 Hospice election periods, election statements, and the hospice certification process. (1) Hospice coverage is available for two ninety-day election periods followed by an unlimited number of sixty-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinitiate an election period for hospice care.

(2) The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

(a) Name and address of the hospice agency that will provide the care;

(b) Documentation that the client is fully informed and understands hospice care and waiver of other medicaid and/or medicare services;

(c) Effective date of the election; and

(d) Signature of the client or the client's authorized representative.

(3) The following describes the hospice certification process:

(a) When a client elects to receive hospice care, the department requires a hospice agency to:

(i) Obtain a signed written certification of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:

(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and

(B) The client's attending physician (if the client has one).

(iii) Place the signed written certification of the client's terminal illness in the client's medical file:

(A) Within sixty days following the day the hospice care begins; and

(B) Before billing the department for the hospice services.

(b) For subsequent election periods, the department requires the hospice agency to:

(i) Obtain a signed written certification statement of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency; and

(iii) Place the written certification of the client's terminal illness in the client's medical file:

(A) Within two calendar days following the beginning of a subsequent election period; and

(B) Before billing the department for the hospice services.

(4) When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1310, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1320 Hospice plan of care. (1) A hospice agency must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with department of health (DOH) requirements as described in WAC 246-335-085, and meet the requirements in this section.

(2) A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

(3) At least two other hospice interdisciplinary team members must review the POC no later than two working days after it is developed.

(4) The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes at least:

(a) A registered nurse;

(b) A social worker; and

(c) One other hospice interdisciplinary team member.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1320, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1330 Hospice—Client care and responsibilities of hospice agencies. (1) A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

(a) Determining if the department has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, the department will rescind the approval. See WAC 388-543-1500.

(b) Communicating with other department programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other department programs include, but are not limited to, programs administered by the aging and disability services administration (ADSA).

(c) Documenting each contact with nonhospice providers.

(2) When a client resides in a nursing facility, the hospice agency must:

(a) Coordinate the client's care with all providers, including pharmacies and medical vendors; and

(b) Provide the same level of hospice care the hospice agency provides to a client residing in their home.

(3) Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

(a) By choosing hospice care from a hospice agency, the client gives up the right to:

(i) Covered medicaid hospice service and supplies received at the same time from another hospice agency; and

(ii) Any covered medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

(b) Services and supplies are not paid through the hospice daily rate if they are:

(i) Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions (see WAC 388-551-1210(3));

(ii) Not covered by the hospice daily rate;

(iii) Provided under a Title XIX medicaid program when the services are similar or duplicate the hospice care services; or

(iv) Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

(4) A hospice agency must have written agreements with all contracted providers.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1330, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

Hospice—Discharges and Notification

WAC 388-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 388-551-1360, the hospice agency must do all of the following:

(1) Within five working days of becoming aware of the client's decision, inform and notify in writing the department's hospice program manager (see WAC 388-551-1400 for further requirements);

(2) Complete a medicaid hospice 5-day notification form (DSHS 13-746) and forward a copy to the appropriate home and community services (HCS) office or community services office (CSO) to notify that the client is discharging from the program;

(3) Notify the client, or the client's authorized representative, that the client's discharge has been reported to the department; and

(4) Document the effective date and details of the discharge in the client's hospice record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1340, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1350 Discharges from hospice care. (1) A hospice agency may discharge a client from hospice care when the client:

(a) Is no longer certified for hospice care;

(b) Is no longer appropriate for hospice care; or

(c) The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five working days, complete a medicaid hospice 5-day notification form (DSHS 13-746) and forward to the department's hospice program manager (see WAC 388-551-1400 for additional requirements), and a copy to the appropriate home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current medical identification (medical ID) card when obtaining medicaid covered healthcare services or supplies, or both; and

(ii) Used until the department issues the client a new medical ID card that identifies that the client is no longer a hospice client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1350, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1360 Ending hospice care (revocations). (1) A client or a client's authorized representative may choose to stop hospice care at any time by signing a revocation statement.

(2) The revocation statement documents the client's choice to stop medicaid hospice care. The revocation statement must include all of the following:

(a) Client's signature (or the client's authorized representative's signature if the client is unable to sign);

(b) Date the revocation was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and revocation dates in the client's hospice records.

(4) When a client revokes hospice care, the hospice agency must:

(a) Within five working days of becoming aware of the client's decision, inform and notify in writing the department's hospice program manager (see WAC 388-551-1400 for additional requirements);

(b) Notify the appropriate home and community services (HCS) office or community services office (CSO) of the revocation by completing and forwarding a copy of the medicaid hospice 5-day notification form (DSHS 13-746) to the appropriate home and community services (HCS) office or community services office (CSO);

(c) Keep the revocation statement in the client's hospice record;

(d) Provide the client with a copy of the revocation statement; and

(e) Inform the client that the revocation statement must be:

(i) Presented with the client's current medical identification (medical ID) card when obtaining medicaid covered healthcare services or supplies, or both; and

(ii) Used until the department issues a new medical ID card that identifies that the client is no longer a hospice client.

(5) After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1360, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1370 When a hospice client dies. When a client dies, the hospice agency must:

(1) Within five working days, inform and notify in writing the department's hospice program manager; and

(2) Notify the appropriate home and community services (HCS) office or community services office (CSO) of the client's date of death by completing and forwarding a copy of the medicaid hospice 5-day notification form (DSHS 13-746) to the appropriate HCS office or CSO.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1370, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1400 Notification requirements for hospice agencies. (1) To be reimbursed for providing hospice services, the hospice agency must complete a medicaid hospice 5-day notification form (DSHS 13-746) and forward to the department's hospice program manager within five working days from when a medical assistance client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the department's hospice program of:

(a) The name and address of the hospice agency;

(b) The date of the client's first day of hospice care;

(c) A change in the client's primary physician;

(d) A client's revocation of the hospice benefit (home or institutional);

(e) The date a client leaves hospice without notice;

(f) A client's discharge from hospice care;

(g) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);

(h) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care.);

(i) A client who is eligible for or becomes eligible for medicare or third party liability (TPL) insurance;

(j) A client who dies; or

(k) A client who transfers to another hospice agency. Both the former agency and current agency must provide the department with:

(i) The client's name, the name of the former hospice agency servicing the client, and the effective date of the client's discharge; and

(ii) The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

(2) The department does not require a hospice agency to notify the hospice program manager when a hospice client is admitted to a hospital for palliative care.

(3) When a hospice agency does not notify the department's hospice program within five working days of the date of the client's first day of hospice care as required in subsection (1)(c) of this section, the department authorizes the hospice daily rate reimbursement effective the fifth working day prior to the date of notification.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1400, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

Hospice—Payment

WAC 388-551-1500 Hospice daily rate—Four levels of hospice care. All services, supplies and equipment related to the client's terminal illness and related conditions are included in the hospice daily rate. The department pays for only one of the following four levels of hospice care per day (see WAC 388-551-1510 for payment methods):

(1) **Routine home care.** Routine home care includes daily care administered to the client at the client's residence.

The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

(2) **Continuous home care.** Continuous home care includes acute skilled care provided to an unstable client during a brief period of medical crisis in order to maintain the client in the client's residence and is limited to:

(a) A minimum of eight hours of acute care provided during a twenty-four-hour day;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care;

(c) Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care; and

(d) In home care only (not care in a nursing facility or a hospice care center).

(3) **Inpatient respite care.** Inpatient respite care includes room and board services provided to a client in a department-approved hospice care center, nursing facility, or hospital. Respite care is intended to provide relief to the client's primary caregiver and is limited to:

(a) No more than six consecutive days; and

(b) A client not currently residing in a hospice care center, nursing facility, or hospital.

(4) **General inpatient hospice care.** General inpatient hospice care includes services administered to a client for pain control or management of acute symptoms. In addition:

(a) The services must conform to the client's written plan of care (POC).

(b) This benefit is limited to brief periods of care in department-approved:

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice care centers.

(b) There must be documentation in the client's medical record to support the need for general inpatient level of hospice care.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1500, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1510 Rates methodology and payment method for hospice agencies. This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The department uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 388-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the department bases payment rates on the Metropolitan Statistical Area (MSA) county location. MSAs are identified in the department's current published billing instructions.

(4) Payment rates for:

(a) Routine and continuous home care services are based on the county location of the client's residence.

(b) Inpatient respite and general inpatient care services are based on the MSA county location of the providing hospice agency.

(5) The department pays hospice agencies for services (not room and board) at a daily rate calculated as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(6) The department:

(a) Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(7) Hospice agencies must bill the department for their services using hospice-specific revenue codes.

(8) For hospice clients in a nursing facility:

(a) The department pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no greater than the nursing facility's current medicaid daily rate.

(9) The department:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(10) The daily rate for authorized out-of-state hospice services is the same as for in-state non-MSA hospice services.

(11) The client's notice of action (award) letter states the amount of participation the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount of the client's participation if the client has any; and

(b) Must show the client's monthly participation on the hospice claim. (Hospice providers may refer to the department's current published billing instructions for how to bill a hospice claim.) If a client has a participation amount that is not reflected on the claim and the department reimburses the amount to the hospice agency, the amount is subject to recoupment by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1510, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1520 Payment method for nonhospice providers. (1) The department pays for hospitals that provide inpatient care to clients in the hospice program for medical conditions not related to their terminal illness according to chapter 388-550 WAC, Hospital services.

(2) The department pays providers who are attending physicians and not employed by the hospice agency, the usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the terminal illness; and

(c) When the client's providers, including the hospice agency, coordinate the health care provided.

(3) The department's aging and disability services administration (ADSA) pays for services provided to a client eligible under the community options program entry system (COPES) directly to the COPES provider.

(a) The client's monthly participation amount, if there is one, for services provided under COPES is paid separately to the COPES provider; and

(b) Hospice agencies must bill the department's hospice program directly for hospice services, not the COPES program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1520, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1530 Payment method for medicaid-medicare dual eligible clients. (1) The department does not pay for any hospice care provided to a client covered by medicare part A (hospital insurance).

(2) The department may pay for hospice care provided to a client:

(a) Covered by medicaid part B (medical insurance); and

(b) Not covered by medicare part A.

(3) For hospice care provided to a medicaid-medicare dual eligible client, hospice agencies are responsible to bill:

(a) Medicare before billing the department;

(b) The department for hospice nursing facility room and board;

(c) The department for hospice care center room and board; and

(d) Medicare for general inpatient care or inpatient respite care.

(4) All the limitations and requirements related to hospice care described in this subchapter apply to the payments described in this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1530, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1800 Pediatric palliative care (PPC) case management/coordination services—General. Through a hospice agency, the department's pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1800, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility. To receive pediatric palliative care (PPC) case management/coordination services, a person must:

(1) Be twenty years of age or younger;

(2) Be a current recipient of the:

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP);

(c) CNP—Alien emergency medical;

(d) LCP-MNP—Alien emergency medical;

(e) Children's health insurance program (SCHIP); and

(3) Have a life-limiting medical condition that requires case management and coordination of medical services due to at least three of the following circumstances:

(a) An immediate medical need during a time of crisis;

(b) Coordination with family member(s) and providers required in more than one setting (i.e. school, home, and multiple medical offices or clinics);

(c) A life-limiting medical condition that impacts cognitive, social, and physical development;

(d) A medical condition with which the family is unable to cope;

(e) A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and

(f) Therapeutic goals focused on quality of life, comfort, and family stability.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1810, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage. (1) The department's pediatric palliative care (PPC) case management/coordination services cover up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC.

(2) One pediatric palliative care contact consists of:

(a) One visit with a registered nurse, social worker, or therapist (for the purpose of this section, the department defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

(i) Pain and symptom management;

(ii) Psychosocial counseling; or

(iii) Education/training.

(b) Two hours or more per month of case management or coordination services to include any combination of the following:

(i) Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);

(ii) Establishing or implementing care conferences;

(iii) Arranging, planning, coordinating, and evaluating community resources to meet the client's needs;

(iv) Visits lasting twenty minutes or less (for example, visits to give injections, drop off supplies, or make appointments for other PPC-related services.); and

(v) Visits not provided in the client's home.

(3) The department does not pay for a pediatric palliative care contact described in subsection (2) of this section when a client is receiving services from any of the following:

(a) Home health program;

(b) Hospice program;

(c) Private duty nursing (private duty nursing can subcontract with PPC to provide services)/medical intensive care;

(d) Disease case management program; or

(e) Any other department program that provides similar services.

(4) The department does not pay for a pediatric palliative care contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1820, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1830 How to become a department-approved pediatric palliative care (PPC) case management/coordination services provider. This section applies to department-enrolled providers who currently do not provide pediatric palliative care (PPC) services to medical assistance clients.

(1) To apply to become a department-approved provider of PPC services, a provider must:

(a) Be a department-approved hospice agency (see WAC 388-551-1300 and 388-551-1305); and

(b) Submit a letter to the department's hospice/PPC program manager requesting to become a department-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

(2) A hospice agency qualifies to provide PPC services when:

(a) All the requirements in this section are met; and

(b) The department provides the hospice agency with written notification.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1830, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements. (1) An eligible provider of pediatric palliative care (PPC) case management/coordination services must do all of the following:

(a) Meet the conditions in WAC 388-551-1300;

(b) Confirm that a client meets the eligibility criteria in WAC 388-551-1810 prior to providing the pediatric palliative care services;

(c) Place in the client's medical record a written order for PPC from the client's physician;

(d) Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of pediatric palliative care services;

(e) Document in the client's medical record:

(i) A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs).

(ii) The medical necessity for those services to be provided in the client's residence; and

(iii) Discharge planning.

(f) Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members;

(g) Assign and make available a PPC case manager (nurse, social worker or therapist) to implement care coordination with community-based providers to assure clarity, effectiveness, and safety of the client's POC;

(h) Complete and fax the pediatric palliative care (PPC) referral and 5-day notification form (DSHS 13-752) to the department's PPC program manager within five working days from date of occurrence of the client's:

(i) Date of enrollment in PPC.

(ii) Discharge from the hospice agency or PPC program when the client:

(A) No longer meets PPC criteria;

(B) Is able to receive all care in the community;

(C) Does not require any services for sixty days; or

(D) Discharges from the PPC program and enrolls in the department's hospice program.

(iii) Transfer to another hospice agency for pediatric palliative care services.

(iv) Death.

(i) Maintain the client's file which includes the POC, visit notes, and all of the following:

(i) The client's start of care date and dates of service;

(ii) Discipline and services provided (in-home or place of service);

(iii) Case management activity and documentation of hours of work; and

(iv) Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g. the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

(j) Provide when requested by the department's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified in subsection (1)(i) of this section.

(2) If the department determines the POC, visit notes, and/or other required information do not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1840, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1850 Pediatric palliative care (PPC) case management/coordination services—Rates methodology. (1) The department determines the reimbursement rate for a pediatric palliative care (PPC) contact described in WAC 388-551-1820 using the average of statewide metropolitan statistical area (MSA) home health care rates for skilled nursing, physical therapy, speech-language therapy and occupational therapy.

(2) The department makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a vender rate change. New rates become effective as directed by the legislature and are effective until the next rate change.

(3) The reimbursement rate for authorized out-of-state PPC services is the same as the in-state non-MSA rate.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1850, filed 8/30/05, effective 10/1/05.]

SUBCHAPTER II—HOME HEALTH SERVICES

WAC 388-551-2000 Home health services—General. The purpose of the medical assistance administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence, subject to the restrictions and limitations in this subchapter.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 388-515 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2000, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2010 Home health services—Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this subchapter:

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

"Brief skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

(1) An injection;

(2) Blood draw; or

(3) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

"Full skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

(1) Observation;

(2) Assessment;

(3) Treatment;

(4) Teaching;

(5) Training;

(6) Management; and

(7) Evaluation.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

"Home health aide" means an individual registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a medicare-certified home health agency with a current medical assistance administration (MAA) provider number. See also WAC 388-551-2000.

"Long-term care" is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department's aging and adult services administration (AASA) or division of developmental disabilities (DDD).

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC 388-551-2210.

"Residence" means a client's home or place of living. (See WAC 388-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through MAA's home health program.)

"Review period" means the three-month period the medical assistance administration (MAA) assigns to a home health agency, based on the address of the agency's main office, during which MAA reviews all claims submitted by that agency.

"Specialized therapy" means skilled therapy services provided to clients that include:

(1) Physical;

(2) Occupational; or

(3) Speech/audiology services.

(See WAC 388-551-2110.)

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2020 Home health services—Eligible clients. (1) Clients in the following fee-for-service MAA programs are eligible to receive home health services subject to the limitations described in this chapter. Clients enrolled in a healthy options managed care plan receive all home health services through their designated plan.

(a) Categorically needy program (CNP);

(b) Limited casualty program - medically needy program (LCP-MNP);

(c) General assistance expedited (GA-X) (disability determination pending); and

(d) Medical care services (MCS) under the following programs:

(i) General assistance - unemployable (GA-U); and

(ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).

(2) MAA does not cover home health services under the home health program for clients in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. MAA evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 388-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

(a) The client requires hospital care due to an emergent medical condition as described in WAC 388-500-0005; and

(b) MAA authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2020, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2030 Home health skilled services—Requirements. (1) MAA reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

(a) Meet the definition of "acute care" in WAC 388-551-2010.

(b) Provide for the treatment of an illness, injury, or disability.

(c) Be medically necessary as defined in WAC 388-500-0005.

(d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.

(e) Be provided under a plan of care (POC), as defined in WAC 388-551-2010 and described in WAC 388-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.

(f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.

(g) Be provided in the client's residence.

(i) MAA does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

(ii) Clients in residential facilities contracted with the state and paid by other programs such as home and community programs to provide limited skilled nursing services, are not eligible for MAA-funded limited skilled nursing services unless the services are prior authorized under the provisions of WAC 388-501-0165.

(h) Be provided by:

(i) A home health agency that is Title XVIII (medicare) certified;

(ii) A registered nurse (RN) prior authorized by MAA when no home health agency exists in the area a client resides; or

(iii) An RN authorized by MAA when the RN is unable to contract with a medicare-certified home health agency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2030, filed 7/15/02, effective 8/15/02.]

WAC 388-551-2100 Covered home health services—Nursing. (1) MAA covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

(2) MAA covers the following home health acute care skilled nursing services, subject to the limitations in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse if the services involve one or more of the following:

(i) Observation;

(ii) Assessment;

(iii) Treatment;

(iv) Teaching;

(v) Training;

(vi) Management; and

(vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

(i) An injection;

(ii) Blood draw; or

(iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

(i) Is willing and capable of learning and managing the client's infusion care; or

(ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

(i) When provided by an MAA-approved infant phototherapy agency; and

(ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

(i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(ii) For up to three home health visits per pregnancy if:

(A) Enrollment in or referral to the following providers of first steps has been verified:

(I) Maternity support services (MSS); or

(II) Maternity case management (MCM); and

(B) The visits are provided by a registered nurse who has either:

(I) National perinatal certification; or

(II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

(3) MAA limits skilled nursing visits provided to eligible clients to two per day.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2100, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2110 Home health services—Specialized therapy. (1) MAA limits specialized therapy visits to one per client, per day, per type of specialized therapy. Specialized therapy is defined in WAC 388-551-2010.

(2) MAA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2110, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2120 Home health aide services. (1) MAA limits home health aide visits to one per day.

(2) MAA reimburses for home health aide services, as defined in WAC 388-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

(a) Skilled nursing services; or

(b) Specialized therapy services.

(3) MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2120, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2130 Noncovered home health services. (1) The Health and Recovery Services Administration (HRSA) does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and disability services administration (ADSA).

(i) HRSA considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, HRSA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) CNP - emergency medical only; and

(ii) LCP-MNP - emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) HRSA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

(m) Home health visits made without a written physician's order, unless the verbal order is:

(i) Documented prior to the visit; and

(ii) The document is signed by the physician within forty-five days of the order being given.

(2) HRSA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) HRSA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-551-2130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2130, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2200 Home health services—Eligible providers. The following may contract with MAA to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare) certified;

(b) Is department of health (DOH) licensed as a home health agency;

(c) Submits a completed, signed core provider agreement to MAA; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by MAA to provide intermittent nursing services when no home health agency exists in the area a client resides;

(b) Is unable to contract with a medicare-certified home health agency;

(c) Submits a completed, signed core provider agreement to MAA; and

(d) Is assigned a provider number.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2200, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2210 Home health services—Provider requirements. For any delivered home health service to be payable, MAA requires home health providers to develop and implement an individualized plan of care (POC) for the client.

(1) The POC must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

(c) Reflect the physician's orders and client's current health status;

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by a physician at least every sixty calendar days, signed by a physician within forty-five days of the verbal order, and returned to the home health agency's file; and

(f) Be available to department staff or its designated contractor(s) on request.

(2) The provider must include in the POC all of the following:

(a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);

(b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;

(c) All secondary medical diagnoses, including date(s) of onset or exacerbation;

(d) The prognosis;

(e) The type(s) of equipment required;

(f) A description of each planned service and goals related to the services provided;

(g) Specific procedures and modalities;

(h) A description of the client's mental status;

(i) A description of the client's rehabilitation potential;

(j) A list of permitted activities;

(k) A list of safety measures taken on behalf of the client; and

(l) A list of medications which indicates:

(i) Any new prescription; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the POC:

(a) A description of the client's functional limits and the effects;

(b) Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the DSHS case manager of admittance; and

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 388-551-2120(3);

(c) All medications administered and treatments provided;

(d) All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;

(e) Signed physician new orders and change orders;

(f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(g) Interdisciplinary and multidisciplinary team communications;

(h) Inter-agency and intra-agency referrals;

(i) Medical tests and results;

(j) Pertinent medical history; and

(k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the POC;

(b) Client response to the POC:

(c) Any clinical change in client status;

(d) Follow-up interventions specific to a change in status with significant clinical findings; and

(e) Any communications with the attending physician.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, client compliance, and client response;

(b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;

(c) If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and

(d) The client's physical system assessment as identified in the POC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2220 Home health services—Provider payments. (1) In order to be reimbursed, the home health provider must bill MAA according to the conditions of payment under WAC 388-502-0150 and other issuances.

(2) Payment to home health providers is:

(a) A set rate per visit for each discipline provided to a client;

(b) Based on the county location of the providing home health agency; and

(c) Updated by general vendor rate changes.

(3) For clients eligible for both medicaid and medicare, MAA may pay for services described in this chapter only when medicare does not cover those services. The maximum payment for each service is medicaid's maximum payment.

(4) Providers must submit documentation to MAA during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(5) After MAA receives the documentation, the MAA medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) MAA may take back or deny payment for any insufficiently documented home health care service when the MAA medical director or designee determines that:

(a) The service did not meet the conditions described in WAC 388-550-2030; or

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

WAC 388-551-3000 Private duty nursing services for clients seventeen years of age and younger. This section applies to private duty nursing services for eligible clients on fee-for-service programs. Managed care clients receive private duty nursing services through their plans (see chapter 388-538 WAC).

(1) **"Private duty nursing"** means four hours or more of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services. Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

(a) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);

(b) Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bilevel positive airway pressure, intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);

(c) Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO_2s, ventilator settings, humidification systems, fluid balance, etc.); and

(d) Interventions (e.g., medications, suctioning, IV's, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

(2) To be eligible for private duty nursing services, a client must meet all the following:

(a) Be seventeen years of age or younger (see chapter 388-71 WAC for information about private duty nursing services for clients eighteen years of age and older);

(b) Be eligible for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-501-0060 and 388-501-0065);

(c) Need continuous skilled nursing care that can be provided safely outside an institution; and

(d) Have prior authorization from the department.

(3) The department contracts only with home health agencies licensed by Washington state to provide private duty nursing services and pays a rate established by the department according to current funding levels.

(4) A provider must coordinate with a division of developmental disabilities case manager and request prior authorization by submitting a complete referral to the department, which includes all of the following:

(a) The client's age, medical history, diagnosis, and current prescribed treatment plan, as developed by the individual's physician;

(b) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;

(c) An emergency medical plan which includes notification of electric, gas and telephone companies as well as local fire department;

(d) Psycho-social history/summary which provides the following information:

(i) Family constellation and current situation;

(ii) Available personal support systems;

(iii) Presence of other stresses within and upon the family; and

(iv) Projected number of nursing hours needed in the home, after discussion with the family or guardian.

(e) A written request from the client or the client's legally authorized representative for home care.

(5) The department approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

(a) The information submitted by the provider is complete;

(b) The care provided will be based in the client's home;

(c) Private duty nursing will be provided in the most cost-effective setting;

(d) An adult family member, guardian, or other designated adult has been trained and is capable of providing the skilled nursing care;

(e) A registered or licensed practical nurse will provide the care under the direction of a physician; and

(f) Based on the referral submitted by the provider, the department determines:

(i) The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;

(ii) The client requires more nursing care than is available through the home health services program; and

(iii) The home care plan is safe for the client.

(6) Upon approval, the department will authorize private duty nursing services up to a maximum of sixteen hours per

day except as provided in subsection (7) of this section, restricted to the least costly equally effective amount of care.

(7) The department may authorize additional hours:

(a) For a maximum of thirty days if any of the following apply:

(i) The family or guardian is being trained in care and procedures;

(ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that noninstitutionalized care is still safe for the client;

(iii) The family or guardian caregiver is ill or temporarily unable to provide care;

(iv) There is a family emergency; or

(v) The department determines it is medically necessary.

(b) After the department evaluates the request according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(8) The department adjusts the number of authorized hours when the client's condition or situation changes.

(9) Any hours of nursing care in excess of those authorized by the department are the responsibility of the client, family or guardian.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-551-3000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.520. 01-05-040, § 388-551-3000, filed 2/14/01, effective 3/17/01.]

Chapter 388-552 WAC
OXYGEN AND RESPIRATORY THERAPY

WAC

WAC 388-552-001 Scope. (1) This chapter applies to:

(a) Medical assistance administration (MAA) clients who require medically necessary **oxygen** and/or respiratory therapy equipment, supplies, and services in their homes and nursing facilities; and

(b) Providers who furnish **oxygen** and respiratory therapy equipment, supplies and services to eligible MAA clients.

(2) Instructions for clients covered by medicare are located in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.]

WAC 388-552-005 Definitions. The following definitions and those in WAC 388-500-0005 apply to this chapter. If a definition in WAC 388-500-0005 differs with the definition in this section, the definition in this section applies. Defined words and phrases are bolded in the text.

"Authorized prescriber" means a health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory therapy equipment, supplies, and services.

"Base year," as used in this chapter, means the year in which the oxygen and respiratory therapy billing instructions' current fee schedule is adopted.

"Maximum allowable" means the maximum dollar amount MAA reimburses a provider for a specific service, supply, or piece of equipment.

"Oxygen" means United States Pure (USP) medical grade liquid or gaseous oxygen.

"Oxygen and respiratory therapy billing instructions" means a booklet containing procedures for billing, which is available by writing to Medical Assistance Administration, Division of Program Support, P.O. Box 45562, Olympia, WA, 98504-5562.

"Oxygen system" means all equipment necessary to provide oxygen to a person.

"Portable system" means a small system which allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence.

"Provider" means a person or company with a signed core provider agreement with MAA to furnish **oxygen** and respiratory therapy equipment, supplies, and services to eligible MAA clients.

"Respiratory care practitioner" means a person certified by the department of health according to chapter 18.89 RCW and chapter 246-928 WAC.

"Stationary system" means equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.]

CLIENT ELIGIBILITY

WAC 388-552-100 Client eligibility. (1) All MAA fee-for-service clients are eligible for **oxygen** and respiratory therapy equipment, supplies, and services when medically necessary, with the following limitations:

(a) Clients on the medically indigent program are not eligible under this chapter; and

(b) Clients on the categorically needy/qualified medicare beneficiaries and medically needy/qualified medicare benefi-

ciaries programs are covered by medicare and medicaid as follows:

(i) If medicare covers the service, MAA will pay the lesser of:

(A) The full co-insurance and deductible amounts due, based upon medicaid's allowed amount; or

(B) MAA's **maximum allowable** for that service minus the amount paid by medicare.

(ii) If medicare does not cover or denies equipment, supplies, or services that MAA covers according to this chapter, MAA reimburses at MAA's **maximum allowable**; except, MAA does not reimburse for clients on the qualified medicare beneficiaries (QMB) only program.

(2) Services for clients enrolled in a healthy options managed care plan receive all **oxygen** and respiratory therapy equipment, supplies, and services through their designated plan, subject to the plan's coverages and limitations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.]

PROVIDERS

WAC 388-552-200 Providers—General responsibilities. (1) The provider must verify that the client's original prescription is signed and dated by the **authorized prescriber** no more than ninety days prior to the initial date of service. The prescription must include, at a minimum:

(a) The client's medical diagnosis, prognosis, and documentation of the medical necessity for **oxygen** and/or respiratory therapy equipment, supplies, and/or services, and any modifications;

(b) If **oxygen** is prescribed:

(i) Flow rate of **oxygen**;

(ii) Estimated duration of need;

(iii) Frequency and duration of **oxygen** use; and

(iv) Lab values or **oxygen** saturation measurements upon the client's discharge from the hospital.

(2) The provider must provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.]

WAC 388-552-210 Required records. (1) A provider must maintain legible, accurate, and complete charts and records for each client. These records must support and justify claims that the provider submits to MAA for reimbursement. Records must include, at a minimum the:

(a) Date(s) of service;

(b) Client's name and date of birth;

(c) Name and title of person performing the service, when it is someone other than the billing practitioner;

(d) Chief complaint or reason for each visit;

(e) Pertinent medical history;

(f) Pertinent findings on examination;

(g) **Oxygen**, equipment, supplies, and/or services prescribed or provided;

(h) The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220;

(i) Description of treatment (when applicable);

(j) Recommendations for additional treatments, procedures, or consultations;

(k) X-rays, tests, and results;

(l) Plan of treatment/care/outcome;

(m) Logs of oxygen saturations and lab values taken to substantiate the medical necessity of continuous **oxygen**, as required by WAC 388-552-220;

(n) Logs of oximetry readings if required by WAC 388-552-380 for a client seventeen years of age or younger; and

(o) Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

(2) The provider must make required charts and records available to DSHS or its contractor(s) upon request.

(3) MAA may require additional information in order to process a submitted claim.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.]

WAC 388-552-220 Requirements for oxygen providers. Oxygen providers must:

(1) Obtain a renewed prescription every six months if the client's condition warrants continued service;

(2) Verify, at least every six months, that **oxygen** saturations or lab values substantiate the need for continued **oxygen** use for each client. The provider may perform the **oxygen** saturation measurements. MAA does not accept lifetime certificates of medical need (CMNs).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.]

WAC 388-552-230 Requirements for infant apnea monitors. (1) MAA does not reimburse for apnea monitors unless the provider has a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care who is responsible for their apnea monitor program.

(2) MAA does not require a confirming second opinion for the initial rental period for diagnoses of apnea of prematurity, primary apnea, obstructed airway, or congenital conditions associated with apnea. For other diagnoses, a neonatologist's confirming assessment and recommendation must be maintained as a second opinion in the client's file. The initial rental period must not exceed six months.

(3) Regardless of diagnosis, the provider must maintain in the client's file, a neonatologist's clinical evaluation justifying each subsequent rental period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.]

WAC 388-552-240 Requirements for respiratory care practitioners. (1) A respiratory care practitioner must comply with chapter 18.89 RCW and chapter 246-928 WAC to qualify for reimbursement.

(2) A respiratory care practitioner must complete at least the following in each client visit:

(a) Check equipment and ensure equipment settings continue to meet the client's needs; and

(b) Communicate with the client's physician if there are any concerns or recommendations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.]

COVERAGE

WAC 388-552-300 Coverage. (1) MAA covers medically necessary oxygen and respiratory therapy equipment, supplies, and services subject to the limitations in this chapter. MAA approves additional oxygen and respiratory therapy equipment, supplies, and services on a case-by-case basis if medically necessary.

(2) MAA does not reimburse for a service or product if any of the following apply:

(a) The service or product is not covered by MAA;

(b) The service or product is not medically necessary;

(c) The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or

(d) The client and provider do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.]

WAC 388-552-310 Coverage—Oxygen and oxygen equipment. (1) MAA reimburses for **oxygen** provided to:

(a) Clients eighteen years of age or older with:

(i) PO_2< = fifty-five mm on room air; or

(ii) SaO_2< = eighty-eighty percent on room air; or

(iii) PaO_2< = fifty-five mm on room air.

(b) Clients seventeen years of age or younger to maintain SaO_2 at:

(i) Ninety-two percent; or

(ii) Ninety-four percent in a child with cor pulmonale or pulmonary hypertension.

(2) MAA may cover spare tanks of **oxygen** and other equipment if the provider and attending physician document that travel distance or potential weather conditions could reasonably be expected to interfere with routine delivery of such equipment and supplies.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.]

WAC 388-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies. (1) MAA covers the rental and/or purchase of medically necessary CPAP equipment and related accessories when all of the following apply:

(a) The results of a prior sleep study indicate the client has sleep apnea;

(b) The client's attending physician determines that the client's sleep apnea is chronic;

(c) CPAP is the least costly, most effective treatment modality;

(d) The item is to be used exclusively by the client for whom it is requested;

(e) The item is FDA-approved; and

(f) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA reimburses for its purchase.

(3) Refer to **oxygen and respiratory therapy billing instructions** to determine which CPAP accessories are covered.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.]

WAC 388-552-330 Coverage—Ventilator therapy, equipment, and supplies. (1) MAA covers medically necessary ventilator equipment rental and related disposable supplies when all of the following apply:

(a) The ventilator is to be used exclusively by the client for whom it is requested;

(b) The ventilator is FDA-approved; and

(c) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA's monthly rental payment includes medically necessary accessories, including, but not limited to: Humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing.

(3) MAA covers a secondary (back-up) ventilator at fifty percent of the monthly rental if medically necessary.

(4) MAA covers the purchase of durable accessories for client-owned ventilator systems according to the fee schedule in the current **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.]

WAC 388-552-340 Coverage—Infant apnea monitor program. (1) A provider must comply with WAC 388-552-230 to qualify for reimbursement for the infant apnea monitor program.

(2) MAA covers infant apnea monitors on a rental basis.

(3) MAA includes all home visits, follow-up calls, and training in the rental allowance.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.]

WAC 388-552-350 Coverage—Respiratory and ventilator therapy. (1) MAA covers prescribed medically necessary respiratory and ventilator therapy services in the home.

(2) Therapy services must be provided by a certified respiratory care practitioner;

(3) MAA does not reimburse separately for respiratory and ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.]

WAC 388-552-360 Coverage—Suction pumps and supplies. (1) MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.

(2) MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:

(a) Travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or

(b) The client requires suctioning while away from the client's place of residence.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.]

WAC 388-552-370 Coverage—Inhalation drugs and solutions. Inhalation drugs and solutions are included in the prescription drug program. Refer to chapter 388-530 WAC.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.]

WAC 388-552-380 Coverage—Oximeters. (1) MAA covers oximeters for clients seventeen years of age or younger when the client has one of the following conditions:

(a) Chronic lung disease, is on supplemental **oxygen**, and is at risk for desaturation with sleep, stress, or feeding;

(b) A compromised or artificial airway, and is at risk for major obstructive events or aspiration events; or

(c) Chronic lung disease, requires ventilator or BIPAP support, and may be at risk for atelectasis or pneumonia as well as hypoventilation.

(2) The provider must review oximetry needs and fluctuations in **oxygen** levels monthly, and log results in the client's records.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.]

WAC 388-552-390 Coverage—Nursing facilities. (1) MAA reimburses according to this chapter for the chronic use of medically necessary **oxygen**, and **oxygen** and respiratory equipment and supplies to eligible clients who reside in nursing facilities.

(2) Nursing facilities are reimbursed in their per diem rate for:

(a) **Oxygen** and **oxygen** equipment and supplies used in emergency situations; and

(b) Respiratory and ventilator therapy services.

(3) Nursing facilities with a "piped" **oxygen** system may submit a written request to MAA for permission to bill MAA for oxygen. See **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.]

REIMBURSEMENT

WAC 388-552-400 Reimbursement for covered services. (1) A provider must bill MAA according to the procedures and codes in the current **oxygen and respiratory therapy billing instructions**.

(2) MAA does not reimburse separately for telephone calls, mileage, or travel time. These services are included in the reimbursement for other equipment and/or services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.]

WAC 388-552-410 Reimbursement methods. MAA bases the decision to rent or purchase medical equipment for a client, or pay for repairs to client-owned equipment, on the least costly and/or equally effective alternative.

(1) **Rental**.

(a) Types of rental equipment:

(i) Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and

(ii) Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client. Refer to the **oxygen and respiratory therapy billing instructions** for detailed information.

(b) The monthly rental rate includes, but is not limited to:

(i) A full service warranty covering the rental period;

(ii) Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;

(iii) All medically necessary accessories and disposable supplies, unless separately billable according to current **oxygen and respiratory therapy billing instructions**;

(iv) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(v) Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(2) **Purchase**.

(a) Purchased equipment becomes the property of the client;

(b) MAA reimburses for:

(i) Equipment that is new at the time of purchase, unless otherwise specified in current **oxygen and respiratory therapy billing instructions**; and

(ii) One maintenance and service visit every six months for purchased equipment.

(c) MAA does not reimburse for:

(i) Defective equipment;

(ii) The cost of materials covered under the manufacturer's warranty; or

(iii) Repair or replacement of equipment if evidence indicates malicious damage, culpable neglect, or wrongful disposition.

(d) The reimbursement rate for purchased equipment includes, but is not limited to:

(i) A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/nonreusable supplies;

(ii) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(iii) The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(e) The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.]

WAC 388-552-420 Reimbursement methodology. MAA, at its discretion, uses the following methods to determine the **maximum allowable** amount for each purchased and rented item and service:

(1) **Monthly rental reimbursement methodology**.

(a) Medicare's fee as of October 31 of the year prior to the base year; or

(b) A **maximum allowable** equal to:

(i) One-tenth of the purchase **maximum allowable** for that product; or

(ii) If MAA does not reimburse for the purchase of that product, one-tenth of the amount calculated using the methodology in subsection (1) of this section.

(2) **Purchase reimbursement methodology**.

(a) Medicare's fee as of October 31 of the year prior to the **base year**; or

(b) A **maximum allowable** equal to the seventieth percentile price of an array of input prices.

(i) The number of input prices included in each array may be limited by MAA based on consideration of product quality, cost, available alternatives, and client needs.

(ii) An input price used in the **maximum allowable** calculation is the lesser of:

(A) Eighty percent of the manufacturer's list or suggested retail price as of October 31 of the **base year**; or

(B) One hundred thirty-five percent of the wholesale acquisition cost as of October 31 of the **base year**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.]

Chapter 388-553 WAC

HOME INFUSION THERAPY/PARENTERAL NUTRITION PROGRAM

WAC

WAC 388-553-100 Home infusion therapy/parenteral nutrition program—General. The medical assistance administration's (MAA's) home infusion therapy/parenteral nutrition program provides the supplies and equipment necessary for parenteral infusion of therapeutic agents to medical assistance clients. An eligible client receives equipment, supplies, and parenteral administration of therapeutic agents in a qualified setting to improve or sustain the client's health.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-100, filed 5/5/04, effective 6/5/04.]

WAC 388-553-200 Home infusion therapy/parenteral nutrition program—Definitions. The following terms and definitions apply to the home infusion therapy/parenteral nutrition program:

"Infusion therapy" means the provision of therapeutic agents or nutritional products to individuals by parenteral infusion for the purpose of improving or sustaining a client's health.

"Intradialytic parenteral nutrition (IDPN)" means intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition.

"Parenteral infusion" means the introduction of a substance by means other than the gastrointestinal tract, referring particularly to the introduction of substances by intravenous, subcutaneous, intramuscular or intramedullary means.

"Parenteral nutrition" (also known as total parenteral nutrition (TPN)) means the provision of nutritional requirements intravenously.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-200, filed 5/5/04, effective 6/5/04.]

WAC 388-553-300 Home infusion therapy/parenteral nutrition program—Client eligibility and assignment. (1) Clients in the following medical assistance administration (MAA) programs are eligible to receive home infusion therapy and parenteral nutrition, subject to the limitations and restrictions in this section and other applicable WAC:

(a) Categorically needy program (CNP);

(b) Categorically needy program - Children's health insurance program (CNP-CHIP);

(c) General assistance - Unemployable (GA-U); and

(d) Limited casualty program - Medically needy program (LCP-MNP).

(2) Clients enrolled in an MAA managed care plan are eligible for home infusion therapy and parenteral nutrition through that plan.

(3) Clients eligible for home health program services may receive home infusion related services according to WAC 388-551-2000 through 388-551-3000.

(4) To receive home infusion therapy, a client must:

(a) Have a written physician order for all solutions and medications to be administered.

(b) Be able to manage their infusion in one of the following ways:

(i) Independently;

(ii) With a volunteer caregiver who can manage the infusion; or

(iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).

(c) Be clinically stable and have a condition that does not warrant hospitalization.

(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply.

(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.

(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:

(i) Running water;

(ii) Electricity;

(iii) Telephone access; and

(iv) Receptacles for proper storage and disposal of drugs and drug products.

(5) To receive parenteral nutrition, a client must meet the conditions in subsection (4) of this section and:

(a) Have one of the following that prevents oral or enteral intake to meet the client's nutritional needs:

(i) Hyperemesis gravidarum; or

(ii) An impairment involving the gastrointestinal tract that lasts three months or longer.

(b) Be unresponsive to medical interventions other than parenteral nutrition; and

(c) Be unable to maintain weight or strength.

(6) A client who has a functioning gastrointestinal tract is not eligible for parenteral nutrition program services when the need for parenteral nutrition is only due to:

(a) A swallowing disorder;

(b) Gastrointestinal defect that is not permanent unless the client meets the criteria in subsection (7) of this section;

(c) A psychological disorder (such as depression) that impairs food intake;

(d) A cognitive disorder (such as dementia) that impairs food intake;

(e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;

(f) A side effect of medication; or

(g) Renal failure or dialysis, or both.

(7) A client with a gastrointestinal impairment that is expected to last less than three months is eligible for parenteral nutrition only if:

(a) The client's physician or appropriate medial provider has documented in the client's medical record the gastrointestinal impairment is expected to last less then three months;

(b) The client meets all the criteria in subsection (4) of this section;

(c) The client has a written physician order that documents the client is unable to receive oral or tube feedings; and

(d) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

(8) A client is eligible to receive intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and

(b) The client meets the criteria in subsection (4) and (5) of this section and other applicable WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-300, filed 5/5/04, effective 6/5/04.]

WAC 388-553-400 Home infusion therapy/parenteral nutrition program—Provider requirements. (1) Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

(a) Have a signed core provider agreement with the medical assistance administration (MAA); and

(b) Be one of the following provider types:

(i) Pharmacy provider;

(ii) Durable medical equipment (DME) provider; or

(iii) Infusion therapy provider.

(2) MAA pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

(a) Are able to provide home infusion therapy within their scope of practice;

(b) Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy/parenteral nutrition is an appropriate course of action;

(c) Have determined that the therapies prescribed and the client's needs for care can be safely met;

(d) Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes;

(e) Meet the requirements in WAC 388-502-0020, including keeping legible, accurate and complete client charts, and providing the following documentation in the client's medical file:

(i) For a client receiving infusion therapy, the file must contain:

(A) A copy of the written prescription for the therapy;

(B) The client's age, height, and weight; and

(C) The medical necessity for the specific home infusion service.

(ii) For a client receiving parenteral nutrition, the file must contain:

(A) All the information listed in (e)(i) of this subsection;

(B) Oral or enteral feeding trials and outcomes, if applicable;

(C) Duration of gastrointestinal impairment; and

(D) The monitoring and reviewing of the client's lab values:

(I) At the initiation of therapy;

(II) At least once per month; and

(III) When the client and/or the client's lab results are unstable.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-400, filed 5/5/04, effective 6/5/04.]

WAC 388-553-500 Home infusion therapy/parenteral nutrition program—Coverage, services, limitations, prior authorization, and reimbursement. (1) The home infusion therapy/parenteral nutrition program covers the following for eligible clients, subject to the limitations and restrictions listed:

(a) Home infusion supplies, limited to one month's supply per client, per calendar month.

(b) Parenteral nutrition solutions, limited to one month's supply per client, per calendar month.

(c) One type of infusion pump, one type of parenteral pump, and/or one type of insulin pump per client, per calendar month and as follows:

(i) All rent-to-purchase infusion, parenteral, and/or insulin pumps must be new equipment at the beginning of the rental period.

(ii) The department covers the rental payment for each type of infusion, parenteral, or insulin pump for up to twelve months. (The department considers a pump purchased after twelve months of rental payments.)

(iii) The department covers only one purchased infusion pump or parenteral pump per client in a five-year period.

(iv) The department covers only one purchased insulin pump per client in a four-year period.

(2) Covered supplies and equipment that are within the described limitations listed in subsection (1) of this section do not require prior authorization for reimbursement.

(3) Requests for supplies and/or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on an individual basis according to the provisions of WAC 388-501-0165 and 388-501-0169.

(4) Department reimbursement for equipment rentals and purchases includes the following:

(a) Instructions to a client or a caregiver, or both, on the safe and proper use of equipment provided;

(b) Full service warranty;

(c) Delivery and pickup; and

(d) Setup, fitting, and adjustments.

(5) Except as provided in subsection (6) of this section, the department does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

(i) The client has a preexisting diagnosis that requires parenteral support; and

(ii) The preexisting diagnosis is not related to the diagnosis that qualifies the client for hospice.

(6) The department pays separately for a client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies when the client:

(a) Resides in a nursing facility; and

(b) Meets the criteria in WAC 388-553-300.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-553-500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-500, filed 5/5/04, effective 6/5/04.]

Chapter 388-554 WAC
ENTERAL NUTRITION PROGRAM

WAC

WAC 388-554-100 Enteral nutrition program—General. The medical assistance administration's (MAA's) enteral nutrition program covers the products, equipment, and supplies to provide medically necessary enteral nutrition to eligible medical assistance clients.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-100, filed 1/28/05, effective 3/1/05.]

WAC 388-554-200 Enteral nutrition program—Definitions. The following terms and definitions and those found in WAC 388-500-0005 apply to the enteral nutrition program:

"BMI" see **"body mass index."**

"Body mass index (BMI)" is a number that shows body weight adjusted by height, and is calculated using inches and pounds or meters and kilograms.

"Enteral nutrition" means the use of medically necessary nutritional products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutritional requirements. Enteral nutritional solutions can be given orally or via feeding tubes.

"Enteral nutrition equipment" means durable medical feeding pumps and intravenous (IV) poles used in conjunction with nutrition supplies to dispense formula to a client.

"Enteral nutrition product" means enteral nutrition formulas and/or products.

"Enteral nutrition supplies" means the supplies, such as nasogastric, gastrostomy and jejunostomy tubes, necessary to allow nutritional support via the alimentary canal or any route connected to the gastrointestinal system.

"Growth chart" is a series of percentile curves that illustrate the distribution of select body measurements (i.e., height, weight, and age) in children published by the Centers for Disease Control and Prevention, National Center for Health Statistics. CDC growth charts: United States. http://www.cdc.gov/growthcharts/

"Nonfunctioning digestive tract" is caused by a condition that affects the body's alimentary organs and their ability to break down and digest nutrients.

"Orally administered enteral nutrition products" means enteral nutrition solutions and products that a client consumes orally for nutritional support.

"Tube-delivery" means the provision of nutritional requirements through a tube into the stomach or small intestine.

"WIC program" (Women, infants and children (WIC) program) is a special supplemental nutrition program managed by the department of health (DOH) that serves to safeguard the health of children up to age five, and low-income pregnant and breastfeeding women who are at nutritional risk by providing them with healthy, nutritious foods to supplement diets, information on healthy eating, and referral to health care.

"Women, infants and children (WIC) program." See **"WIC program."**

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-200, filed 1/28/05, effective 3/1/05.]

WAC 388-554-300 Enteral nutrition program—Client eligibility. (1) Clients in the following medical assistance programs are eligible to receive oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies, subject to the limitations in this chapter and other applicable WAC:

(a) Categorically needy program (CNP);

(b) Children's health insurance program (CHIP) (same scope of coverage as CNP);

(c) General assistance - Unemployable (GA-U);

(d) Limited casualty program - Medically needy program (LCP-MNP);

(e) Alien emergency medical program - CNP; and

(f) Alien emergency medical program - LCP-MNP.

(2) All clients younger than age twenty-one must be evaluated by a certified dietitian with a current provider number within thirty days of initiation of enteral nutrition products, and periodically (at the discretion of the certified dietitian) while receiving enteral nutrition products. See WAC 388-554-400 (2)(h) for provider requirements.

(3) Clients enrolled in an MAA managed care plan are eligible for oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies through that plan. If a client becomes enrolled in a managed care plan before MAA completes the purchase (or rental, if applicable) of prescribed enteral products, necessary equipment and supplies:

(a) MAA rescinds the purchase until the managed care primary care provider (PCP) evaluates the client; and

(b) The managed care plan's applicable reimbursement policies apply to the purchase of the products, equipment, or supplies, or rental of the equipment, as applicable.

(4) To receive orally administered enteral nutrition products, a client must:

(a) Have a valid written physician order from a physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C) for all enteral nutrition products;

(b) When required, have the provider obtain prior authorization as described in WAC 388-554-700;

(c) Meet the conditions in this section and other applicable WAC;

(d) Be able to manage their feedings in one of the following ways:

(i) Independently; or

(ii) With a caregiver who can manage the feedings; and

(e) Have at least one of the following medical conditions, subject to the criteria listed:

(i) Malnutrition/malabsorption as a result of a stated primary diagnosed disease. The client must have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is younger than age three; or

(B) A body mass index (BMI) of:

(I) Less than or equal to the fifth percentile if the client is older than age three and younger than age eighteen; or

(II) Less than or equal to 18.5 if the client is age eighteen or older.

(ii) Acquired immune deficiency syndrome (AIDS). The client must be in a wasting state and have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is younger than age three; or

(B) A BMI of:

(I) Less than or equal to the fifth percentile if the client is older than age three and younger than age eighteen; or

(II) Less than or equal to 18.5 if the client is age eighteen or older.

(iii) Amino acid, fatty acid, and carbohydrate metabolic disorders;

(iv) Dysphagia. The client must:

(A) Need to transition from tube feedings to oral feedings or require thickeners to aid swallowing; and

(B) Be evaluated by:

(I) A speech therapist; or

(II) An occupational therapist who specializes in dysphagia.

(v) Chronic renal failure. The client:

(A) Must be receiving dialysis; and

(B) Have a fluid restrictive diet in order to use nutrition bars.

(vi) Malignant cancer(s). The client must be receiving chemotherapy.

(vii) Decubitus pressure ulcers. The client must have:

(A) Stage three or greater decubitus pressure ulcers; and

(B) An albumin level of 3.2 or below.

(viii) Failure to thrive. The client must have a disease or medical condition that is only organic in nature and not due to cognitive, emotional, or psychological impairment. In addition, the client must have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is
younger than age three;

(B) A BMI of less than or equal to the fifth percentile if the client is at least age three but younger than age eighteen; and

(C) A BMI of less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of one hundred sixty or below if the client is age eighteen or older.

(5) A client is eligible to receive delivery of orally administered enteral nutrition products in quantities sufficient to meet the client's medically authorized needs, not to exceed a one-month supply. To receive the next month's delivery of authorized products, the client's record must show documentation of the need to refill the products. See WAC 388-554-400 for provider requirements.

(6) To receive tube-delivered enteral nutrition products, necessary equipment and supplies, a client must:

(a) Have a valid written physician order from a physician, ARNP, or PA-C;

(b) Meet the conditions in this section and other applicable WAC; and

(c) Be able to manage their tube feedings in one of the following ways:

(i) Independently; or

(ii) With a caregiver who can manage the feedings; and

(d) Have at least one of the following medical conditions, subject to the criteria listed:

(i) A nonfunction or disease of the structures that normally permit food to reach the small bowel; or

(ii) A disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength that is properly proportioned to the client's overall health status.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-300, filed 1/28/05, effective 3/1/05.]

WAC 388-554-400 Enteral nutrition program—Provider requirements. (1) A provider of all oral enteral nutri-

tion products and tube-delivered enteral nutrition products and necessary equipment and supplies must:

(a) Have a current core provider agreement with the medical assistance administration (MAA); and

(b) Be one of the following provider types:

(i) Pharmacy provider; or

(ii) Durable medical equipment (DME) provider.

(2) To be paid for oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies, an eligible provider must:

(a) Meet the requirements in WAC 388-502-0020 and other applicable WAC;

(b) Obtain prior authorization (PA), if required, before delivery to the client and before billing MAA. See WAC 388-554-700 for PA requirements;

(c) Deliver orally administered enteral nutrition products in quantities sufficient to meet a client's medically authorized needs, not to exceed a one-month supply;

(d) Bill MAA for the authorized products and submit a claim for payment to MAA with a date of service being the same as the shipping date;

(e) Confirm with the client and document in the client's record that the next month's delivery of authorized orally administered enteral nutrition products is necessary (see WAC 388-554-300(5)). MAA will not reimburse automatic periodic delivery of products;

(f) Notify and inform the client's physician if the client has indicated the product is not being used as prescribed;

(g) Keep legible, accurate, and complete charts in the client's record to justify the medical necessity of the items provided and include:

(i) For each item billed, a copy of the prescription. The prescription must:

(A) Be signed and dated by the prescribing physician;

(B) List the client's medical condition and exact daily caloric amount of needed enteral product; and

(C) State the reason why the client is unable to consume enough traditional food to meet nutritional requirements.

(ii) The medical reason the specific enteral product, equipment, and/or supply is prescribed; and

(iii) For a client who meets the women, infants and children (WIC) program's target population as defined in WAC 388-554-200, verification from the WIC program that the client:

(A) Is not eligible for WIC program services;

(B) Is eligible for WIC program services, but nutritional needs exceed the WIC program's maximum per calendar month allotment; or

(C) The WIC program cannot provide the prescribed product.

(h) For a client younger than age twenty-one, retain a copy of each required certified dietitian evaluation, as described in WAC 388-554-300(2).

(3) MAA may recoup any payment made to a provider for authorized enteral nutrition products if the requirements in subsection (2) of this section and other applicable WAC are not met.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-400, filed 1/28/05, effective 3/1/05.]

WAC 388-554-500 Orally administered enteral nutrition products—Coverage, limitations, and reimbursement. (1) The enteral nutrition program covers and reimburses medically necessary orally administered enteral nutrition products, subject to:

(a) Prior authorization requirements under WAC 388-554-700;

(b) Duration periods determined by the department;

(c) Delivery requirements under WAC 388-554-400(2); and

(d) The provisions in other applicable WAC.

(2) Except as provided in subsection (3) of this section, the department does not pay separately for orally administered enteral nutrition products:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

(i) The client has a preexisting medical condition that requires enteral nutritional support; and

(ii) The preexisting medical condition is not related to the diagnosis that qualifies the client for hospice.

(3) The department pays separately for a client's orally administered enteral nutrition products when the client:

(a) Resides in a nursing facility;

(b) Meets the criteria in WAC 388-554-300; and

(c) Needs enteral nutrition products to meet one hundred percent of the client's nutritional needs.

(4) The department does not cover or pay for orally administered enteral nutrition products when the client's nutritional need can be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs.

(5) The department:

(a) Determines reimbursement for oral enteral nutrition products according to a set fee schedule;

(b) Considers Medicare's current fee schedule when determining maximum allowable fees;

(c) Considers vendor rate increases or decreases as directed by the Legislature; and

(d) Evaluates and updates the maximum allowable fees for oral enteral nutrition products at least once per year.

(6) The department evaluates a request for orally administered enteral nutrition products that are in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(7) The department evaluates a request for orally administered enteral nutrition products that are listed as noncovered in this chapter according to the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-500, filed 1/28/05, effective 3/1/05.]

WAC 388-554-600 Tube-delivered enteral nutrition products and related equipment and supplies—Coverage, limitations, and reimbursement. (1) The enteral nutrition program covers and reimburses the following, subject to the limitations listed in this section and the provisions in other applicable WAC:

(a) Tube-delivered enteral nutrition products;

(b) Tube-delivery supplies;

(c) Enteral nutrition pump rental and purchase;

(d) Nondisposable intravenous (IV) poles required for enteral nutrition product delivery; and

(e) Repairs to equipment.

(2) The department covers up to twelve months of rental payments for enteral nutrition equipment. After twelve months of rental, the department considers the equipment purchased and it becomes the client's property.

(3) The department requires a provider to furnish clients new or used equipment that includes full manufacturer and dealer warranties for one year.

(4) The department covers only one:

(a) Purchased pump per client in a five year period; and

(b) Purchased nondisposable IV pole per client for that client's lifetime.

(5) The department's reimbursement for covered enteral nutrition equipment and necessary supplies includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or the client's caregiver in the appropriate use of the equipment and necessary supplies.

(6) A provider is responsible for any costs incurred to have another provider repair equipment if all of the following apply:

(a) Any equipment that the department considers purchased requires repair during the applicable warranty period;

(b) The provider is unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) If a rental equipment the department considers to have been purchased must be replaced during the warranty period, the department recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client. All of the following must apply:

(a) The provider is unable to fulfill the warranty; and

(b) The client still needs the equipment.

(8) The department rescinds any authorization for prescribed equipment if the equipment was not delivered to the client before the client:

(a) Loses medical eligibility;

(b) Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related condition(s);

(c) Becomes eligible for a department-contracted managed care plan; or

(d) Dies.

(9) Except as provided in subsection (10) of this section, the department does not pay separately for tube-delivered enteral nutrition products or necessary equipment or supplies when a client:

(a) Resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) Has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

(i) The client has a preexisting medical condition that requires enteral nutritional support; and

(ii) The preexisting medical condition is not related to the diagnosis that qualifies the client for hospice.

(10) The department pays separately for a client's tube-delivered enteral nutrition products and necessary equipment and supplies when:

(a) The client resides in a nursing facility;

(b) The client meets the eligibility criteria in WAC 388-554-300; and

(c) Use of enteral nutrition products meets one hundred percent of the client's nutritional needs.

(11) The department determines reimbursement for tube-delivered enteral nutrition products and necessary equipment and supplies using the same criteria described in WAC 388-554-500(5).

(12) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies that are in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(13) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies, that are listed as noncovered in this chapter, under the provision of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-600, filed 1/28/05, effective 3/1/05.]

WAC 388-554-700 Enteral nutrition products and supplies—Prior authorization requirements. (1) All requests for oral enteral nutrition products, repairs to equipment, and replacement of necessary supplies for tube-delivery of enteral nutrition products require prior authorization as described in this section. See also WAC 388-501-0165.

(2) When MAA receives an initial request for prior authorization, the prescription(s) for those items cannot be older than three months from the date MAA receives the request.

(3) MAA may authorize orally administered enteral nutrition products that are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medical necessity is established and the provider furnishes all of the following information to MAA:

(a) A copy of the signed and dated physician order completed by the prescribing physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C), which includes client's medical condition and exact daily caloric amount of prescribed enteral nutrition product;

(b) Documentation from the client's physician, ARNP, or PA-C that verifies all of the following:

(i) The client has one of the medical conditions listed in WAC 388-554-300 (4)(e);

(ii) The client's physical limitations and expected outcome;

(iii) The client's current clinical nutritional status, including the relationship between the client's diagnosis and nutritional need;

(iv) For a client age eighteen or older, the client's recent weight loss history and a comparison of the client's actual weight to ideal body weight and current body mass index (BMI);

(v) For a client younger than age eighteen, the client's growth history and a comparison to expected weight gain, and:

(A) An evaluation of the weight-for-length percentile if the client is younger than age three; or

(B) An evaluation of the BMI if the client is older than age three and younger than age eighteen.

(v) Documentation explaining why less costly, equally effective products or traditional foods are not appropriate (see WAC 388-554-500(4));

(vi) The client's likely expected outcome if enteral nutritional support is not provided; and

(vii) Number of days or months the enteral nutrition products, equipment, and/or necessary supplies are required.

(4) A provider may resubmit a request for prior authorization for oral enteral nutrition products or replacement of necessary supplies for tube-delivery of enteral nutrition products that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-700, filed 1/28/05, effective 3/1/05.]

WAC 388-554-800 Enteral nutrition program requirements for WIC program-eligible clients. Clients who qualify for supplemental nutrition from the women, infants, and children (WIC) program must receive supplemental nutrition through that program. The medical assistance administration (MAA) may cover the enteral nutrition products and supplies for WIC program-eligible clients only when all of the following are met:

(1) The provider requests prior authorization for the enteral nutrition product or supply;

(2) Documentation from the WIC program is attached to the request form that verifies:

(a) The client's enteral nutrition need is in excess of WIC program allocations; or

(b) The WIC program cannot supply the prescribed product; and

(3) The client meets the enteral nutrition program requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-800, filed 1/28/05, effective 3/1/05.]

Chapter 388-556 WAC

MEDICAL CARE—OTHER SERVICES PROVIDED

WAC

WAC 388-556-0100 Chemical dependency treatment services. The department covers chemical dependency treatment services, as defined in chapter 388-805 WAC, for medicaid and children's health clients. Coverage is limited to services performed by providers defined in WAC 388-502-0010.

[Statutory Authority: RCW 74.08.090, 74.09.035, and 74.50.055. 00-18-032, § 388-556-0100, filed 8/29/00, effective 9/29/00.]

WAC 388-556-0200 Chiropractic services for children. (1) MAA will pay only for chiropractic services:

(a) For MAA clients who are:

(i) Under twenty-one years of age; and

(ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.

(b) That are:

(i) Medically necessary, safe, effective, and not experimental;

(ii) Provided by a chiropractor licensed in the state where services are provided; and

(iii) Within the scope of the chiropractor's license.

(c) Limited to:

(i) Chiropractic manipulative treatments of the spine; and

(ii) X rays of the spine.

(2) Chiropractic services are paid according to fees established by MAA using methodology set forth in WAC 388-531-1850.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-16-031, § 388-556-0200, filed 7/24/00, effective 8/24/00.]

WAC 388-556-0300 Personal care services. The department pays for personal care services for a Title XIX categorically needy medicaid client as provided under chapter 388-71 WAC, Home and community programs.

[Statutory Authority: RCW 74.08.090. 00-17-057, § 388-556-0300, filed 8/9/00, effective 9/9/00.]

WAC 388-556-0400 Limitations on services available to recipients of categorically needy medical assistance. (1) Organ transplants are limited to the cornea, heart, heart-lung, kidney, kidney-pancreas, liver, pancreas, single lung, and bone marrow.

(2) The department shall provide treatment, dialysis, equipment, and supplies for acute and chronic nonfunctioning kidneys when the client is in the home, hospital, or kidney center as described under WAC 388-540-005.

(3) Detoxification and medical stabilization are provided to chemically-using pregnant women in a hospital.

(4) The department shall provide detoxification of acute alcohol or other drug intoxication only in a certified detoxification center or in a general hospital having a detoxification provider agreement with the department.

(5) The department shall provide outpatient chemical dependency treatment in programs qualified under chapter

275-25 WAC and certified under chapter 275-19 WAC or its successor.

(6) The department may require a second opinion and/or consultation before the approval of any elective surgical procedure.

(7) The department designates diagnoses that may require surgical intervention:

(a) Performed in other than a hospital in-patient setting; and

(b) Requiring prior approval by the department for a hospital admission.

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-556-0400, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-556-0400, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-86-005, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-005, filed 10/25/95, effective 10/28/95; 93-17-038 (Order 3620), § 388-86-005, filed 8/11/93, effective 9/11/93; 92-03-084 (Order 3309), § 388-86-005, filed 1/15/92, effective 2/15/92; 90-17-122 (Order 3056), § 388-86-005, filed 8/21/90, effective 9/21/90; 90-12-051 (Order 3009), § 388-86-005, filed 5/31/90, effective 7/1/90; 89-18-033 (Order 2860), § 388-86-005, filed 8/29/89, effective 9/29/89; 89-13-005 (Order 2811), § 388-86-005, filed 6/8/89; 88-06-083 (Order 2600), § 388-86-005, filed 3/2/88. Statutory Authority: 1987 1st ex.s. c 7. 88-02-034 (Order 2580), § 388-86-005, filed 12/31/87. Statutory Authority: RCW 74.08.090. 87-12-050 (Order 2495), § 388-86-005, filed 6/1/87; 84-02-052 (Order 2060), § 388-86-005, filed 1/4/84; 83-17-073 (Order 2011), § 388-86-005, filed 8/19/83; 83-01-056 (Order 1923), § 388-86-005, filed 12/15/82; 82-10-062 (Order 1801), § 388-86-005, filed 5/5/82; 82-01-001 (Order 1725), § 388-86-005, filed 12/3/81; 81-16-033 (Order 1685), § 388-86-005, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-005, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-005, filed 10/9/80; 78-06-081 (Order 1299), § 388-86-005, filed 6/1/78; 78-02-024 (Order 1265), § 388-86-005, filed 1/13/78; Order 994, § 388-86-005, filed 12/31/74; Order 970, § 388-86-005, filed 9/13/74; Order 911, § 388-86-005, filed 3/1/74; Order 858, § 388-86-005, filed 9/27/73; Order 781, § 388-86-005, filed 3/16/73; Order 738, § 388-86-005, filed 11/22/72; Order 680, § 388-86-005, filed 5/10/72; Order 630, § 388-86-005, filed 11/24/71; Order 581, § 388-86-005, filed 7/20/71; Order 549, § 388-86-005, filed 3/31/71, effective 5/1/71; Order 453, § 388-86-005, filed 5/20/70, effective 6/20/70; Order 419, § 388-86-005, filed 12/31/69; Order 264 (part); § 388-86-005, filed 11/24/67.]

WAC 388-556-0500 Medical care services under state-administered cash programs. Medical care services (MCS) are state-administered medical care services provided to a client receiving cash benefits under the general assistance-unemployable (GA-U) program or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program. For a client eligible for MCS:

(1) The department of social and health services (DSHS) covers only the medically necessary services within the applicable program limitations listed in the MCS column under WAC 388-501-0060.

(2) DSHS does not cover medical services received outside the state of Washington unless the medical services are provided in a border area listed under WAC 388-501-0175.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-556-0500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-009, § 388-556-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-556-0600 Mental health services. Mental health-related services are available to eligible clients under chapter 388-862 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, 71.24.035. 00-24-053, § 388-556-0600, filed 11/30/00, effective 12/31/00.]

Chapter 388-557 WAC
CHRONIC CARE MANAGEMENT

WAC

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;

(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 388-561 WAC

TRUSTS, ANNUITIES, AND LIFE ESTATES—EFFECT ON MEDICAL PROGRAMS

WAC

WAC 388-561-0001 Definitions. "Annuitant" means a person or entity that receives the income from an annuity.

"Annuity" means a policy, certificate or contract that is an agreement between two parties in which one party pays a lump sum to the other, and the other party agrees to guarantee payment of a set amount of money over a set amount of time. The annuity may be purchased at one time or over a set period of time and may be bought individually or with a group. It may be revocable or irrevocable. The party guaranteeing payment can be an:

(1) Individual; or

(2) Insurer or similar body licensed and approved to do business in the jurisdiction in which the annuity is established.

"Beneficiary" means an individual(s) designated in the trust who benefits from the trust. The beneficiary can also be called the grantee. The beneficiary and the grantor may be the same person.

"Designated for medical expenses" means the trustee may use the trust to pay the medical expenses of the beneficiary. The amount of the trust that is designated for medical expenses is considered an available resource to the beneficiary. Payments are a third party resource.

"Disbursement" or **"distribution"** means any payment from the principal or proceeds of a trust, annuity, or life estate to the beneficiary or to someone on their behalf.

"Discretion of the trustee" means the trustee may decide what portion (up to the entire amount) of the principal of the trust will be made available to the beneficiary.

"Exculpatory clause" means there is some language in the trust that legally limits the authority of the trustee to distribute funds from a trust if the distribution would jeopardize eligibility for government programs including medicaid.

"For the sole benefit of" means that for a transfer to a spouse, blind or disabled child, or disabled individual, the transfer is arranged in such a way 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.

"Grantor" means an individual who uses his assets or funds to create a trust. The grantor may also be the beneficiary.

"Income beneficiary" means the person receiving the payments may only get the proceeds of the trust. The principal is not available for disbursements. If this term is used, the principal of the trust is an unavailable resource.

"Irrevocable" means the legal instrument cannot be changed or terminated in any way by anyone.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Principal" means the assets that make up the entity. The principal includes income earned on the principal that has not been distributed. The principal is also called the corpus.

"Proceeds" means the income earned on the principal. It is usually interest, dividends, or rent. When the proceeds are not distributed, they become part of the principal.

"Pooled trust" means a trust meeting all of the following conditions:

(1) It contains funds of more than one disabled individual, combined for investment and management purposes;

(2) It is for the sole benefit of disabled individuals (as determined by SSA criteria);

(3) It was created by the disabled individuals, their parents, grandparents, legal guardians, or by a court;

(4) It is managed by a nonprofit association with a separate account maintained for each beneficiary; and

(5) It contains a provision that upon the death of the individual, for any funds not retained by the trust, the state will receive all amounts remaining in the individual's separate account up to the total amount of medicaid paid on behalf of that individual.

"Revocable" means the legal instrument can be changed or terminated by the grantor, or by petitioning the court. A legal instrument that is called irrevocable, but that can be terminated if some action is taken, is revocable for the purposes of this section.

"Sole-benefit trust" means an irrevocable trust established for the sole-benefit of a spouse, blind or disabled child, or disabled individual. In a sole-benefit trust no one but the individual named in the trust receives benefit from the trust in any way either at the time the trust is established or at any time during the life of the primary beneficiary. A sole-benefit trust may allow for reasonable costs to trustees for management of the trust and reasonable costs for investment of trust funds.

"Special needs trust" means an irrevocable trust meeting all of the following conditions:

(1) It is for the sole benefit of a disabled individual (as determined by SSA criteria) under sixty-five years old;

(2) It was created by the individual's parent, grandparent, legal guardian, or by a court; and

(3) It contains a provision that upon the death of the individual, the state will receive the amounts remaining in the

trust up to the total amount of medicaid paid on behalf of the individual.

"Testamentary trust" means a trust created by a will from the estate of a deceased person. The trust is paid out according to the will.

"Trust" means property (such as a home, cash, stocks, or other assets) is transferred to a trustee for the benefit of the grantor or another party. The department includes in this definition any other legal instrument similar to a trust. For annuities, refer to WAC 388-561-0200.

"Trustee" means an individual, bank, insurance company or any other entity that manages and administers the trust for the beneficiary.

"Undue hardship" means the client would be unable to meet shelter, food, clothing, and health care needs if the department applied the transfer of assets penalty.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-06-048, § 388-561-0001, filed 2/28/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0001, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0100 Trusts. (1) The department determines how trusts affect eligibility for medical programs.

(2) The department disregards trusts established, on or before April 6, 1986, for the sole benefit of a client who lives in an intermediate care facility for the mentally retarded (ICMR).

(3) For trusts established on or before August 10, 1993 the department counts the following:

(a) If the trust was established by the client, client's spouse, or the legal guardian, the maximum amount of money (payments) allowed to be distributed under the terms of the trust is considered available income to the client if all of the following conditions apply:

(i) The client could be the beneficiary of all or part of the payments from the trust;

(ii) The distribution of payments is determined by one or more of the trustees; and

(iii) The trustees are allowed discretion in distributing payments to the client.

(b) If an irrevocable trust doesn't meet the conditions under subsection (3)(a) then it is considered either:

(i) An **unavailable** resource, if the client established the trust for a beneficiary other than the client or the client's spouse; or

(ii) An **available** resource in the amount of the trust's assets that:

(A) The client could access; or

(B) The trustee distributes as actual payments to the client and the department applies the transfer of assets rules of WAC 388-513-1363, 388-513-1364 or 388-513-1365.

(c) If a revocable trust doesn't meet the description under subsection (3)(a):

(i) The full amount of the trust is an available resource of the client if the trust was established by:

(A) The client;

(B) The client's spouse, and the client lived with the spouse; or

(C) A person other than the client or the client's spouse only to the extent the client had access to the assets of the trust.

(ii) Only the amount of money actually paid to the client from the trust is an available resource when the trust was established by:

(A) The client's spouse, and the client did not live with the spouse; or

(B) A person other than the client or the client's spouse; and

(C) Payments were distributed by a trustee of the trust.

(iii) The department considers the funds a resource, not income.

(4) For trusts established on or after August 11, 1993:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed to the trust by the client are available to the client when part of the trust assets were contributed by any other person.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of distributions from the trust.

(d) For a revocable trust established as described under subsection (4)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (4)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (4)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client is an available resource. When payment is made from such irrevocable trusts, we will consider the payments as:

(A) Income to the client when payment is to or for the client's benefit; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(ii) A trust from which a payment cannot be made to or for the client's benefit is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(5) For trusts established on or after August 1, 2003:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client or the client's spouse;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed other than by will to the trust by either the client or the client's spouse are available to the client or the client's spouse when part of the trust assets were contributed by persons other than the client or the client's spouse.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of the distributions from the trust.

(d) For a revocable trust established as described under subsection (5)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (5)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (5)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client or the client's spouse is an available resource. When payment is made from such irrevocable trusts, the department will consider the payment as:

(A) Income to the client or the client's spouse when payment is to or for the benefit of either the client or the client's spouse; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the benefit of the client or the client's spouse;

(ii) A trust from which a payment cannot be made to or for the benefit of the client or client's spouse is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client or client's spouse is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(6) Trusts established on or after August 11, 1993 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC 388-475-0050) and the trust:

(i) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(ii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, up to the amount of medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC 388-475-0050), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

(D) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(E) A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, up to the amount of medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(7) Trusts established on or after August 1, 2003 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC 388-475-0050) and the trust:

(i) Is irrevocable;

(ii) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(iii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC 388-475-0050), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

(D) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(E) A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(8) Trusts described in subsection (6)(a) and (7)(a) continue to be considered an unavailable resource even after the individual becomes age sixty-five. However, additional transfers made to the trust after the individual reaches age sixty-five would be considered an available resource and would be subject to a transfer penalty.

(9) The department does not apply a penalty period to transfers into a trust described in subsections (6)(b) and (7)(b) if the trust is established for the benefit of a disabled individual under age sixty-five as described in WAC 388-513-1363 and 388-513-1364 and the transfer is made to the trust before the individual reaches age sixty-five.

(10) The department considers any payment from a trust to the client to be unearned income. Except for trusts described in subsection (6), the department considers any payment to or for the benefit of either the client or client's spouse as described in subsections (4)(e) and (5)(e) to be unearned income.

(11) The department will only count income received by the client from trusts and not the principal, if:

(a) The beneficiary has no control over the trust; and

(b) It was established with funds of someone other than the client, spouse or legally responsible person.

(12) This section does not apply when a client establishes that undue hardship exists.

(13) WAC 388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366 apply under this section when the department determines that a trust or a portion of a trust is a transfer of assets.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-561-0100, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-13-113, § 388-561-0100, filed 6/17/03, effective 8/1/03. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0100, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0200 Annuities established prior to November 1, 2008. (1) The department determines how annuities affect eligibility for medical programs.

(2) A revocable annuity is considered an available resource.

(3) An irrevocable annuity established prior to May 1, 2001 is not an available resource when issued by an individual, insurer, or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

(4) The income from an irrevocable annuity, meeting the requirements of this section, is considered in determining eligibility and the amount of participation in the total cost of care. The annuity itself is not considered a resource or income.

(5) An annuity established on or after May 1, 2001 and before November 1, 2008 will be considered an available resource unless it:

(a) Is irrevocable;

(b) Is paid out in equal monthly amounts within the actuarial life expectancy of the annuitant;

(c) Is issued by an individual, insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established; and

(d) Names the department as the beneficiary of the remaining funds up to the total of medicaid funds spent on the client during the client's lifetime. This subsection only applies if the annuity is in the client's name.

(6) An irrevocable annuity established on or after May 1, 2001 and before November 1, 2008 that is not scheduled to be paid out in equal monthly amounts, can still be considered an unavailable resource if:

(a) The full pay out is within the actuarial life expectancy of the client; and

(b) The client:

(i) Changes the scheduled pay out into equal monthly payments within the actuarial life expectancy of the annuitant; or

(ii) Requests that the department calculate and budget the payments as equal monthly payments within the actuarial life expectancy of the annuitant. The income from the annuity remains unearned income to the annuitant.

(7) An irrevocable annuity, established prior to May 1, 2001 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty period of ineligibility, determined according to WAC 388-513-1365, may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy.

(8) An irrevocable annuity, established on or after May 1, 2001 and before November 1, 2008 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy. The penalty for a client receiving:

(a) Long-term care benefits will be a period of ineligibility (see WAC 388-513-1365).

(b) Other medical benefits will be ineligibility [ineligible] in the month of application.

(9) An irrevocable annuity is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), of the client;

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), of the client.

(10) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, UNLESS the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 08-20-117 and 08-21-083, § 388-561-0200, filed 9/30/08 and 10/14/08, effective 4/1/09. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0200, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0201 Annuities established on or after November 1, 2008. (1) The department determines how annuities affect eligibility for medical programs. Applicants and recipients of medicaid must disclose to the state any interest the applicant or spouse has in an annuity.

(2) A revocable annuity is considered an available resource.

(3) The following annuities are not considered available resources:

(a) An annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986;

(b) Purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code of 1986;

(c) A simplified employee pension (within the meaning of section 408 of the Internal Revenue Code of 1986); or

(d) A Roth IRA described in section 408A of the Internal Revenue Code of 1986.

(4) The purchase of an annuity established on or after November 1, 2008, will be considered as an available resource unless it:

(a) Is immediate, irrevocable, nonassignable; and

(b) Is paid out in equal monthly amounts with no deferral and no balloon payments:

(i) Over a term equal to the actuarial life expectancy of the annuitant;

(ii) Over a term that is not less than five years if the actuarial life expectancy of the annuitant is at least five years; or

(iii) Over a term not less than the actuarial life expectancy of the annuitant, if the actuarial life expectancy of the annuitant is less than five years.

(iv) Actuarial life expectancy shall be determined by tables that are published by the office of the chief actuary of the social security administration (http://www.ssa.gov/OACT/STATS/table4c6.html).

(c) Is issued by an individual, insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established;

(d) Names the state as the remainder beneficiary when the applicant is the annuitant:

(i) In the first position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services; or

(ii) In the second position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services, if there is a community spouse, or a minor or disabled child as defined in WAC 388-475-0050 (b) and (c) who is named as the beneficiary in the first position.

(e) Names the state as the beneficiary upon the death of the community spouse for the total amount of medical assistance paid on behalf of the individual at any time of any payment from the annuity if a community spouse is the annuitant;

(f) Names the state as the beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual at the time of any payment from the annuity, including both long-term care services and waiver services, unless the annuitant has a community spouse or minor or disabled child, as defined in WAC 388-475-0050 (b) and (c). If the annuitant has a community spouse or minor or disabled child, such spouse or child may be named as beneficiary in the first position, and the state shall be named as beneficiary in the second position:

(i) If the community spouse, minor or disabled child, or representative for a child named as beneficiary is in the first position as described in (f) and transfers his or her right to receive payments from the annuity for less than fair market value, then the state shall become the beneficiary in the first position.

(5) If the annuity is not considered a resource, the stream of income produced by the annuity is considered available income.

(6) An irrevocable annuity established on or after November 1, 2008 that meets all of the requirements of subsection (4) except that it is not immediate or scheduled to be paid out in equal monthly amounts will not be treated as a resource if:

(a) The full pay out is within the actuarial life expectancy of the annuitant; and

(b) The annuitant:

(i) Changes the scheduled pay out into equal monthly payments within the actuarial life expectancy of the annuitant; or

(ii) Requests that the department calculate and budget the payments as equal monthly payments within the actuarial life expectancy of the annuitant beginning with the month of eligibility. The income from the annuity remains unearned income to the annuitant.

(7) An irrevocable annuity, established on or after November 1, 2008 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource.

(8) An irrevocable annuity established on or after November 1, 2008 that meets all of the requirements of subsection (4) or (5) is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), of the client; or

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child of the client.

(9) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, unless the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

(10) Nothing in this section shall be construed as preventing the department from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity other than an annuity described in subsections (3), (4), and (5).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 08-20-117 and 08-21-083, § 388-561-0201, filed 9/30/08 and 10/14/08, effective 4/1/09.]

WAC 388-561-0300 Life estates. (1) The department determines how life estates affect eligibility for medical programs.

(2) A life estate is an excluded resource when either of the following conditions apply:

(a) It is property other than the home, which is essential to self-support or part of an approved plan for self-support; or

(b) It cannot be sold due to the refusal of joint life estate owner(s) to sell.

(3) Remaining interests of excluded resources in subsection (2) may be subject to transfer of asset penalties under WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(4) Only the client's proportionate interest in the life estate is considered when there is more than one owner of the life estate.

(5) A client or a client's spouse, who transfers legal ownership of a property to create a life estate, may be subject to transfer-of-resource penalties under WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(6) When the property of a life estate is transferred for less than fair market value (FMV), the department treats the transfer in one of two ways:

(a) For noninstitutional medical, the value of the uncompensated portion of the resource is combined with other nonexcluded resources; or

(b) For institutional medical, a period of ineligibility will be established according to WAC 388-513-1363, 388-513-1364 and 388-513-1365.

[Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-561-0300, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0300, filed 3/5/01, effective 5/1/01.]

Chapter 388-700 WAC

JUVENILE REHABILITATION ADMINISTRATION—PRACTICES AND PROCEDURES

(Formerly chapter 275-37 WAC)

WAC

WAC 388-700-0005 What definitions apply to this chapter? The following definitions apply to this chapter:

"Assistant secretary" means the assistant secretary of the juvenile rehabilitation administration.

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Contractor" means a department of social and health services (DSHS)/juvenile rehabilitation administration (JRA) contractor and all employees and all subcontractors of that contractor.

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

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"JRA youth" or **"juvenile"** means a juvenile offender under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Limited access" means supervised access to a juvenile(s) that is the result of the person's regularly scheduled activities or work duties.

"Preponderance of the evidence" means a determination by the secretary that the alleged sexual misconduct more likely than not occurred, or an admission of sexual misconduct has been made.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Reasonable cause" means a reason that would motivate a person of ordinary intelligence under the circum-

stances to believe that an act of sexual misconduct may have occurred.

"Regular access" means unsupervised access to a juvenile(s), for more than a nominal amount of time, that is the result of the person's regularly scheduled activities or work duties.

"Secretary" means the secretary of the department of social and health services.

"Sexual contact" means any touching of the sexual or other intimate parts of a person done for the purpose of gratifying sexual desire of either party or a third party.

"Sexual intercourse" has its ordinary meaning and:

(1) Occurs upon any penetration, however slight; and

(2) Also means any penetration of the vagina or anus however slight, by an object, when committed on one person by another, whether such persons are of the same or opposite sex, except when such penetration is accomplished for medically recognized treatment or diagnostic purposes; and

(3) Also means any act of sexual contact between persons involving the sex organs of one person and the mouth or anus of another whether such persons are of the same or opposite sex.

"Suspend" means to remove from unsupervised access to any JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0005, filed 11/27/00, effective 12/28/00.]

BACKGROUND CHECKS

WAC 388-700-0010 When are background checks required? JRA must conduct background checks on prospective employees, volunteers, and individual contracted service providers who will have regular access to juveniles. Background checks may be conducted on prospective employees, volunteers, and individual contracted service providers who will have limited access to juveniles.

(1) Procedures must be established in order to investigate and determine suitability of a person in a position who will have regular access or limited access to juveniles.

(2) Employees, volunteers or individual contracted service providers who are authorized for regular access do not require the presence of another person cleared through the designated background check process during the performance of their duties.

(3) The presence of another person cleared through the designated background check process is required for people authorized to have limited access to juveniles.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0010, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0015 What crimes prohibit "regular access" to juveniles? Effective September 1, 1998, potential employees, volunteers, and individual contracted service providers must not be hired, engaged, or authorized in a position which allows regular access if the individual has been convicted of:

(1) Any felony sex offense as defined in RCW 9.94A.030 and 9A.44.130;

(2) Any crime specified in chapter 9A.44 RCW when the victim was a juvenile in the custody of or under the jurisdiction of JRA as stated in RCW 13.40.570; or

(3) Any violent offense as defined in RCW 9.94A.030.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0015, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0020 What are the reporting requirements for criminal convictions? Effective September 1, 1998 employees, volunteers, and individual contracted service providers who are authorized for regular access to a juvenile(s) must report any conviction of a crime identified in WAC 388-700-0015. The report must be made to the person's supervisor within seven days of conviction. Failure to report within seven days constitutes misconduct under Title 50 RCW. Employees, volunteers, and individual contracted service providers who have been convicted of offenses in WAC 388-700-0015 must not have regular access to a juvenile(s).

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0020, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0025 Is a contracting agency required to do background checks? JRA must require background checks to be conducted on prospective employees and volunteers of contracting agencies if the person will have regular access to juveniles.

(1) Requirements of WAC 388-700-0010, 388-700-0015, and 388-700-0020 must be met by contracted service providers.

(2) The contracted service provider or designee of an agency contracting with JRA for the provision of a community facility must ensure background check investigations are conducted according to department licensing requirements.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0025, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES

WAC 388-700-0030 What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred? If there is reasonable cause to believe that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, the secretary must immediately remove the JRA employee from access to JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0030, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0035 What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred? If the preponderance of the evidence finds that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, or upon a guilty plea or conviction for any crime specified in chapter 9A.44 RCW when the victim was an offender, the secretary must immediately institute proceedings to terminate the employee.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0035, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA CONTRACTORS

WAC 388-700-0040 What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred? The secretary requires the individual contractor, or employee of a contractor, when there is reasonable cause to believe he/she has had sexual intercourse or sexual contact with a JRA youth, to be immediately removed from access to any JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0040, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0045 What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred? (1) If there is a preponderance of evidence that sexual intercourse or sexual contact between a JRA contractor and a JRA youth occurred, the secretary must inform the contractor that the individual employee is disqualified from employment with a contractor in any position with access to JRA youth.

(2) A contract with a contractor who has had an employee who has been disqualified for employment based on a preponderance of evidence that he or she has had sexual intercourse or sexual contact with a JRA youth, must not be renewed until the secretary determines that significant progress has been made by the contractor to reduce the likelihood that any of its employees or subcontractors have sexual intercourse or sexual contact with a JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0045, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

WAC 388-700-0050 What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will? DSHS will not take any action against a person who is employed or contracted by JRA who has sexual intercourse or sexual contact with a JRA youth and it is found to have been against the employed or contracted person's will.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0050, filed 11/27/00, effective 12/28/00.]

Chapter 388-710 WAC

CONSOLIDATED JUVENILE SERVICES PROGRAMS

WAC

WAC 388-710-0005 Definitions. "Administration" means activities and costs necessary for management and support of a consolidated juvenile services program.

"Application" means the document requesting state funds for specific projects under the consolidated juvenile services program.

"Community input" means information received from local entities which must include, unless impracticable: Providers, judges, law enforcement, juvenile court staff, social service agencies, schools, tribes, organizations representing communities of color, as well as other persons with an interest in juvenile justice. An existing advisory group, committee, or public forum may be used to gather input provided such groups include representation from the entities listed above.

"Director" means the director of the division of community programs/juvenile rehabilitation administration or his or her designee.

"Division" means the division of community programs of the juvenile rehabilitation administration.

"Outcome" means specific changes in the lives of youth and families which lead to a decrease in recidivism.

"Participating county" means a county or counties applying under this chapter.

"Program administrator" or **"administrator"** means the person designated to administer the consolidated juvenile services program in the juvenile court.

"Project" means a specific intervention or program performed as a part of consolidated juvenile services.

"Project supervisor" or **"supervisor"** means a person designated to supervise a project or projects in the consolidated juvenile services program.

"Regional administrator" means the regional administrator of one of the division's six administrative regions, or his or her designee.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0005, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0010 Establishment of a consolidated juvenile services program. (1) Request to participate.

A request by a county or group of counties to participate under this chapter must include a signed resolution or letter of intent submitted to the regional administrator by the executive body expressing intent to participate. The request must include a statement that consolidated juvenile services funds will not be used to replace county funds for existing programs. For those counties with juvenile detention facilities, the counties must include a statement indicating standards of operation as outlined under RCW 13.06.050 are in place.

(2) Program planning process and approval.

(a) Each participating county must develop a program application for the delivery of services and must agree to comply with the provisions of this chapter.

(b) The application must incorporate community input and respond to community comments, which must include but not be limited to:

(i) Efforts to identify and utilize existing community services;

(ii) Appropriate linkage to and support from other elements of the existing juvenile justice, education, and social

service systems to reduce or eliminate barriers to effective family centered service delivery;

(iii) Efforts to address racial disproportionality; and

(iv) Efforts to address issues specific to the Americans with Disabilities Act as it relates to client and family service delivery.

(c) Written guidelines and instructions for the application must be provided by the division. The application must be developed in consultation with the regional administrator to ensure the coordination of state, county, and private sector resources within regional boundaries and must be submitted to the regional administrator for review and approval.

(d) The division may provide technical assistance in the development of the application.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0010, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0015 General provisions. (1) Access to services and use of existing community resources. Program administrators must ensure all juveniles participating in the program have access to appropriate services, activities, and opportunities.

(2) All juveniles served by projects covered under this chapter must be afforded judicial due process in all contacts, especially those which may result in a more restrictive intervention.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0015, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0020 Organization. The organizational structure of the program is the prerogative of the juvenile court participating under this chapter and must not be dictated by these standards.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0020, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0025 Administration. (1) Administrators and supervisors are responsible for the implementation of the program and the accomplishment of stated activities and outcomes.

(2) Administrators or supervisors must meet at least annually with the regional administrator to review progress toward the achievement of outcomes.

(3) Case records and management information.

(a) Juvenile offender records must minimally contain a case plan, based upon assessed factors related to risk to reoffend, methods of intervention and a termination/closing report summarizing case activity and outcomes.

(b) The provisions of chapter 13.50 RCW pertaining to the maintenance and confidentiality of social and legal information apply to all programs and projects covered under this chapter.

(c) Administrators and/or supervisors must provide necessary statistical data to maintain the division's management information system and must maintain sufficient data to evaluate program effectiveness and outcomes.

(4) Change in project.

(a) Modification of a project requires the advance written approval of the regional administrator.

(b) The administrator must send written notification to the regional administrator prior to the movement of funds between programs. The regional administrator must confirm in writing all notifications received.

(c) Contract amendments must be processed through the juvenile rehabilitation administration regional office and are necessary when:

(i) Total contract budget amounts are increased or decreased;

(ii) A project is added or deleted;

(iii) The total number of full-time employees in the consolidated programs increases from the original contract number.

(5) Each participating county must ensure program staff receive training necessary to implement programs covered under this chapter.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0025, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0030 Monitoring of performance and evaluation of program impact. (1) It is the responsibility of the administrator to submit monthly reports, annual narrative reports, corrective action plans and reports, and other reports as specified in the division's application, budget, and monitoring instructions to the regional administrator.

(2) The regional administrator must submit to the director a biennial report of each program.

(3) The regional administrator, may at any time, request a formal program/project or fiscal audit and may also request other available technical services to assist in monitoring and evaluating the program/projects.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0030, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0035 Distribution of funds and fiscal management. Funding constraints.

(1) Funds for programs covered by this chapter must be utilized for the achievement of the outcomes stated for each project.

(2) Failure on the part of any project to perform in accordance with the provisions of this chapter may result in the termination or reduction of funds.

(3) The administrator is responsible for the management of all fiscal matters related to the program. The program must comply with state and local policies and procedures, the terms and conditions of the contract, and the application, budget, and monitoring instructions as outlined by the juvenile rehabilitation administration.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0035, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0040 Exceptions to rules. The juvenile court may request in writing to the director a waiver of the specific requirements of this chapter when the imposition of such requirements can be shown to be detrimental or impractical to overall program operations. The director must consider each waiver request individually and promptly advise the applicant in writing of the director's decision regarding the waiver and explain the basis for such decision.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0040, filed 7/24/00, effective 8/24/00.]

Chapter 388-720 WAC

COLLECTION OF COSTS OF SUPPORT, TREATMENT, AND CONFINEMENT OF JUVENILES UNDER RCW 13.40.220

(Formerly chapter 275-47 WAC)

WAC

WAC 388-720-0010 Definitions. (1) "Juvenile" means juvenile offender sentenced to confinement in the department, other than an offender for whom a parent is approved to receive adoption support under chapter 74.13 RCW.

(2) "Department" means the department of social and health services, state of Washington.

(3) "Gross income" means the total income from all sources, received by the parent, the juvenile, or other children of the parent remaining in the household, other than a stepchild, as determined by the department.

(4) "Parent" means the parent of the juvenile or other person legally obligated to care for and support the juvenile, not including a stepparent.

(5) "Parents and dependents" means the juvenile's parent or parents, a stepparent living in the home who has no income, any child on whom the parent may claim a federal income tax deduction, not including the juvenile confined to the department, and any stepchild for whom the parent is the sole means of support.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0010, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-010, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0020 Cost reimbursement schedule and ability to pay. As provided for in RCW 13.40.220 the office of financial recovery may negotiate payment schedules and the methods used to satisfy costs of support, treatment and confinement with parents and other legally obligated persons, on behalf of the department. The results of the application of this rule may be appealed as provided for in RCW 13.490.220 (4) and (6) and Part IV Adjudicative Proceedings, of chapter 34.05 RCW, Administrative Procedure Act. A parent or other legally obligated person shall pay a percentage of gross income to the department for the cost of support, treatment and confinement of the juvenile. Ability to pay will be determined by the application of the information provided by a parent or other legally obligated person in the financial information statement to the reimbursement schedule below:

Monthly Gross Income	Percentage of Gross Income Ordered for Reimbursement of Costs Number of Parents and Dependents Remaining in Household							
	1	2	3	4	5	6	7	8+
TANF or $0 - 600	0	0	0	0	0	0	0	0
$601 - 1000	8%	6%	4%	2%	0	0	0	0
$1001 - 2000	12%	10%	8%	6%	4%	2%	0	0
$2001 - 3000	16%	14%	12%	10%	8%	6%	4%	2%
$3001 - 4000+	18%	16%	14%	12%	10%	8%	6%	4%

(1) Within fifteen days of receipt of the financial information statement, a parent or other legally obligated person shall complete, sign and mail the statement to the department. Based on the statement and on other information available to it, the department shall determine the parent's gross income, the number of parents and dependents, and the reimbursement obligation, and shall serve on the parent a notice and finding of financial responsibility.

(2) If a parent or legally obligated person fails to timely provide a financial statement, the reimbursement obligation shall be twenty-three hundred dollars per month.

(3) If the juvenile's parents or other legally obligated person reside in separate households, each parent shall be liable for reimbursement.

(4) The gross income of a parent shall be reduced by the amount the parent pays in spousal maintenance to the juvenile's parent, which is gross income to the receiving parent. The gross income of a parent or other legally obligated person shall be reduced by the amount of current child support paid for any child, including the juvenile offender. This credit shall be available when the support is paid to any section of the department or to any other person legally entitled to receive those support payments, pursuant to court order or administrative order for a child the parent did not claim as a dependent under the reimbursement schedule.

(5) Reimbursement may not exceed the cost of care as determined by the department.

(6) The reimbursement obligation commences the day the juvenile enters the custody of the department, regardless of when the notice and finding of financial responsibility is received by the parent. A monthly reimbursement obligation shall be reduced on a pro rata basis for any days in which the juvenile was not in the custody of the department.

(7) The parent or other legally obligated person of the juvenile shall be exempt from the payment of the cost of the juvenile's care in the state facility if the parent or other legally obligated person receives adoption support or is eligible to receive adoption support for the juvenile offender; or if the parent, or other legally obligated person, or such person's child, spouse, or spouse's child, was the victim of the offense for which the juvenile was committed to the department.

[Statutory Authority: RCW 13.40.220. 04-05-080, § 388-720-0020, filed 2/17/04, effective 3/19/04; 00-22-019, recodified as § 388-720-0020, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-020, filed 12/2/96, effective 1/2/97; 94-15-009 (Order 3752), § 275-47-020, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0030 Hearing. A parent may request a hearing under RCW 13.40.220(5) to contest a notice and finding of financial responsibility issued by the department. The department shall ensure the hearing is governed by chap-

ter 34.05 RCW and chapter 388-02 WAC. The sole issues at the hearing include whether the:

(1) Person receiving the notice and finding of financial responsibility is a parent of the juvenile; and

(2) Department correctly:

(a) Determined the parent's gross income and the number of parents and dependents; and

(b) Calculated the reimbursement obligation in accordance with the reimbursement schedule as described under WAC 388-720-0020.

[Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0030, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-030, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0040 Modifications. (1) A parent may modify the parent's financial statement upon a change in gross income or in the number of persons residing in the household only if the change decreases the reimbursement obligation by one hundred dollars per month or more. A decrease may be granted only from the date on which the request for modification is made, and may not be applied retroactively.

(2) A parent shall file a financial statement modification if a change in gross income or the number of persons residing in the household increases the reimbursement obligation by one hundred dollars per month or more. An increase may be applied retroactively.

(3) The department will issue a new notice and finding of financial responsibility upon receipt of a modified financial statement as defined in subsections (1) or (2) of this section. The department may also issue a new notice based upon its own review if the conditions of subsection (1) or (2) of this section are met.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0040, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-040, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0050 Powers of the administrative law judge. The administrative law judge in the final order rendered after the hearing conducted in accordance with WAC 388-720-0030 shall include the name and age of the juvenile in that final order. The administrative law judge shall also indicate the parent's or other legally obligated person's monthly liability amount for the period of the juvenile's confinement beginning with the date the child enters the custody of the department. The administrative law judge shall not establish in the final order any amount constituting a repayment figure of any accrued obligation of the parent but shall indicate in the final order that any accrued obligation shall be paid by the parent to the department's office of financial recovery (OFR) and that OFR will be responsible for determining the method of repayment of the parent's accrued obligation.

The administrative law judge shall also include a statement in the final order that the parent's financial obligation is collectible by OFR and that should the parent fail to comply with any payment plan entered into by OFR and the parent, or the parent fails to pay the amount set out in the final order, OFR shall be authorized to take legal collection action to recover the amounts due from the parent. Legal collection action can include, but is not limited to:

(1) The filing of liens against the real and personal property of the parent; or

(2) The issuance of a garnishment order against the wages, bank accounts, or other property of the responsible persons.

[Statutory Authority: RCW 34.05.020, 13.40.220. 03-01-044, § 388-720-0050, filed 12/10/02, effective 1/10/03. Statutory Authority: RCW 13.40.-220. 00-22-019, amended and recodified as § 388-720-0050, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-050, filed 12/2/96, effective 1/2/97.]

Chapter 388-730 WAC

PLACEMENT OF JUVENILE OFFENDERS COMMITTED TO THE JUVENILE REHABILITATION ADMINISTRATION (JRA)

(Formerly chapter 275-46 WAC)

WAC

WAC 388-730-0010 Definitions. As used in this chapter:

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Community placement eligibility requirements" means requirements developed by JRA that must be met by a youth to demonstrate progress in treatment and low public safety risk, which justify an institutional minimum or minimum security classification for the youth.

"Initial security classification assessment" means a written instrument, developed by JRA and administered by diagnostic staff, to determine to what extent a juvenile is a threat to public safety for the purpose of determining the juvenile's security classification when the juvenile initially is committed to JRA.

"JRA" means juvenile rehabilitation administration, department of social and health services.

"Juvenile" means a person under the age of twenty-one who has been sentenced to a term of confinement under the supervision of the department under RCW 13.40.185.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Residential treatment and care program" means a single family residence operated for the care of juveniles committed to the department under RCW 13.40.185.

"Separate living unit" means sleeping quarters and areas used for daily living activities not specific to treatment and education programs located in a building, wing, or on a different floor which separates resident groups.

"Service provider" means the entity that operates a community facility or is contracted to provide a residential treatment and care program.

"Specialized treatment program" means a program that addresses additional rehabilitation needs such as sex offender treatment, drug/alcohol treatment, mental health interventions, gang intervention, gender/age specific intervention and other programs meeting specific rehabilitation needs of juveniles.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0010, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0010, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]-410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.-210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-010, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-010, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0015 Assessment. (1) Risk assessment and treatment needs must be the basis of placement decisions involving juveniles.

(2) JRA must ensure juveniles are assessed to determine appropriate placement and treatment programming. Ongoing risk and needs assessment must occur during a juvenile's commitment to JRA.

(3) Risk assessment must include:

(a) Risk to public safety;

(b) Risk for sexually aggressive behavior; and

(c) Risk for vulnerability to sexual aggression.

(4) JRA must use a security classification system to assist in placement decisions.

(5) Student records and information as described in RCW 72.05.425 are required for juvenile offender risk assessment, security classification assignment, and JRA community placement decisions. Designated school officials must ensure student records are provided to the identified juvenile court or JRA representative as required in RCW 28A.600.475 and 13.40.480.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0015, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-015, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0020 Security classifications. (1) There are four JRA security classifications:

(a) Maximum;

(b) Medium;

(c) Institutional minimum; and

(d) Minimum.

(2) A juvenile's initial security classification is determined using the initial security classification assessment. A juvenile's security classification may be changed at any time, and be reviewed at regular intervals as determined by JRA policy.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0020, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-020, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-020, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0030 Maximum security. (1) A maximum security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires maximum security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as maximum security must:

(a) Reside in an institution with the capability of:

(i) Security windows;

(ii) Locked exterior doors;

(iii) Lockable single-person rooms; and

(iv) A security fence.

(b) Be permitted movement between secured buildings only if accompanied by a close staff escort;

(c) Be confined to facility grounds, except for court appearances or emergencies, in which case a staff escort, and transportation in restraints and in a security vehicle, are required; and

(d) Be allowed authorized leave only for emergency and medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0030, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-030, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-030, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0040 Medium security. (1) A medium security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires medium security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as medium security must:

(a) Reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) Receive during movement a staff escort, continuous visual surveillance, or telephone/radio staff verification of departures and arrivals, unless the program administrator determines such measures are unnecessary;

(c) Be confined to facility grounds, except for:

(i) Participation in work crews or other programs outside the facility that require a close staff escort; and

(ii) Court appearances or emergencies, in which case a staff escort, and transportation in a security vehicle and/or in restraints, are required.

(d) Be allowed authorized leave only for emergency or medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0040, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-040, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-040, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0050 Institutional minimum. (1) An institutional minimum classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment;

(b) Indicated by the community placement eligibility requirements unless a recent incident indicates the juvenile no longer meets these requirements; or

(c) The assistant secretary for JRA or designee approves an override of the medium security classification.

(2) Even if eligible under subsection (1) of this section, a juvenile must not receive an institutional minimum security classification if:

(a) The assistant secretary for JRA, or designee, signs an administrative override disapproving institutional minimum classification and assigning the juvenile a higher security classification; or

(b) The juvenile is a sex offender who meets the requirements for civil commitment referral under chapter 71.09 RCW or is classified as a risk level III under RCW 13.40.217.

(3) A juvenile classified as institutional minimum security:

(a) Must reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) May be permitted:

(i) Unescorted movement on facility grounds;

(ii) Participation in work crews or other programs outside the facility with a close staff escort;

(iii) Unescorted participation in community work, educational and community service programs, and family treatment or other activities to strengthen family ties, for up to twelve hours per day; and

(iv) Authorized leave pursuant to RCW 13.40.205.

(4) A juvenile on institutional minimum security must be transferred to minimum security upon the availability of an appropriate community placement if:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0050, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-050, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-050, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0060 Minimum security. (1) The provisions of WAC 388-730-0050 also apply to a juvenile classified as minimum security, except the juvenile must reside in a community facility, residential treatment and care program, or a community commitment program facility (CCP) rather than in an institution.

(2) Juveniles must not be placed in a community facility or residential treatment and care program until:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

(3) In addition to the provisions of WAC 388-730-0050 (3)(b)(iii), minimum security juveniles may be permitted unescorted participation in treatment programs in the community that do not involve the family for up to twelve hours per day.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0060, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0060, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-060, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-060, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0065 Special placement restrictions. Certain placement restrictions apply to community facilities and residential treatment and care programs that are commonly used by and under the jurisdiction of both JRA and the children's administration.

(1) When juveniles under commitment to JRA are assessed as a high to moderate risk for sexually aggressive behavior, they may not be placed in a community facility or residential treatment and care program with youths under the jurisdiction of children's administration unless:

(a) They are placed in a separate living unit solely for juveniles currently under the jurisdiction of JRA; or

(b) They are placed in a program that contracts specifically for the provision of services to sexually aggressive youth.

(2) Juveniles under commitment to JRA for a class A felony may not be placed in these community facilities unless:

(a) They are housed in a separate living unit solely for juveniles currently under the jurisdiction of JRA;

(b) They are placed in a community facility or residential treatment and care program that is a specialized treatment program and the juvenile is not assessed as sexually aggressive under RCW 13.40.470; or

(c) They are placed in a community facility or residential treatment and care program that is a specialized treatment program housing one or more sexually aggressive youth and the juvenile is not assessed as sexually vulnerable under RCW 13.40.470.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0065, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0065, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-065, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0070 Residential disciplinary standards. (1) Serious violations by a juvenile include:

(a) Escape or attempted escape;

(b) Violence toward others with intent to harm and/or resulting in significant bodily injury;

(c) Involvement in or conviction of a criminal offense under investigation by law enforcement or awaiting adjudication for behavior that occurred during current placement;

(d) Extortion or blackmail that threatens the safety or security of the facility or community;

(e) Setting or causing an unauthorized fire with intent to harm self, others, or property, or with reckless disregard for the safety of others;

(f) Possession or manufacture of weapons or explosives, or tools intended to assist in escape;

(g) Interfering with staff or service providers in performing duties relating to the security and/or safety of the facility or community;

(h) Intentional property damage in excess of one thousand five hundred dollars;

(i) Possession, use, or distribution of drugs or alcohol, or use of inhalants;

(j) Rioting or inciting others to riot;

(k) Refusal of urinalysis or search; or

(l) Other behaviors which threaten the safety or security of the facility, its staff, or residents or the community.

(2) Other violations by a juvenile placed in a community facility or residential treatment and care program include:

(a) Unaccounted for time when a juvenile is away from the community facility or residential treatment and care program;

(b) Violation of conditions of authorized leave;

(c) Intimidation or coercion against any person;

(d) Misuse of medication such as hoarding medication or taking another person's medication;

(e) Self-mutilation, self tattooing, body piercing, or assisting others to do the same;

(f) Intentional destruction of property valued at less than fifteen hundred dollars;

(g) Fighting;

(h) Unauthorized withdrawal of funds with intent to commit other violations;

(i) Suspensions or expulsions from school or work;

(j) Violations of school, employment or volunteer work agreements related to custody and security concerns;

(k) Escape talk;

(l) Sexual contact or any other behavior, not defined as a serious violation, resulting in a referral to the department of licensing, child protective services, or law enforcement; or

(m) Lewd or disruptive behavior in the community.

(3) Juveniles must be held accountable when there is reasonable cause to believe they have committed a violation.

(a) Whenever a juvenile placed in a community facility or residential treatment and care program commits a serious violation, the juvenile must be returned to an institution. The JRA program administrator who receives a service provider report of a serious violation must make arrangements to transfer the juvenile to an institution as soon as possible. Juveniles may be placed in a secure JRA or contracted facility pending transportation to an institution.

(b) Sanctions for serious violations committed by juveniles in an institution, and additional sanctions for serious violations committed by juveniles returned to an institution, must include one or more of the following:

(i) Loss of privileges for up to thirty days;

(ii) Loss of program level; or

(iii) Room confinement up to seventy-two hours.

(c) Sanctions for serious violations may also include, but are not limited to, one or more of the following:

(i) Change in release date;

(ii) Referral for prosecution;

(iii) Transfer to an intensive management unit;

(iv) Increase in security classification;

(v) Reprimand and loss of points;

(vi) Restitution; or

(vii) Community service.

(d) Sanctions for violations listed in WAC 388-730-0070(2) may include transfer to a higher security facility and must include one or more of the following:

(i) Loss or privileges;

(ii) Loss of program level;

(iii) Room confinement up to seventy-two hours;

(iv) Change in release date;

(v) Reprimand and/or loss of points;

(vi) Additional restitution; or

(vii) Community service.

(4) When a sanction is imposed, the juvenile must also receive a counseling intervention to address the violation.

(5) If the proposed sanctions for any violation includes extending the juvenile's established release date, the juvenile must be entitled to:

(a) Notice of an administrative review to consider extension of the release date and a written statement of the incident;

(b) An opportunity to be heard before a neutral review chairperson;

(c) Present oral or written statements, and call witnesses unless testimony of a witness would be irrelevant, repetitive, unnecessary, or would disrupt the orderly administration of the facility;

(d) Imposition of the sanction only if the administrative review chairperson finds by a preponderance of the evidence that the serious violation did occur; and

(e) A written decision, stating the reasons for the decision, by the administrative review chairperson.

(6) Each superintendent, regional administrator and service provider must clearly post, or make readily available, the list of serious violations and possible sanctions in all living units.

(7) Each program administrator must adopt procedures for implementing the requirements of this section.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0070, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0070, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-070, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-070, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0080 Documenting and reporting violations committed by juveniles in residential facilities. (1) All serious violations and violations listed in WAC 388-730-0070(2) must be documented in an incident report. The incident report must include:

(a) Circumstances leading up to the violation(s);

(b) A description of the violation;

(c) Response by staff;

(d) Response by the juvenile(s) involved in the incident; and

(e) Sanctions imposed or recommended for the violation(s).

(2) Service providers must:

(a) Forward all incident reports to the JRA program administrator no later than twenty-four hours after the behavior is discovered; and

(b) Verbally report serious violations to the JRA program administrator immediately.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0080, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-080, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0090 Service provider penalty schedule. (1) Whenever a service provider contracts with the JRA to operate a community facility or residential treatment and care program, the contracted service provider must report any known violation as required in WAC 388-730-0080.

(2) If the contracted service provider fails to report violations within the prescribed time frames, the JRA must impose one or more of the following remedies:

(a) Imposition of a corrective action plan to be completed as determined by the program administrator.

(b) Imposition of the following monetary penalties:

(i) The first time fines are imposed on a service provider, the penalty must be at the rate of fifty dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(ii) Subsequent fines imposed on the service provider during the same calendar year must be at the rate of seventy-five dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(c) Order to stop placement until a corrective action plan is submitted, approved by the program administrator, and implemented.

(d) Termination of the contract for convenience if it is determined such termination is in the best interests of the department.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0090, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0090, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-090, filed 8/31/98, effective 9/1/98.]

Chapter 388-740 WAC
JUVENILE PAROLE REVOCATION

(Formerly chapter 275-30 WAC)

WAC

WAC 388-740-0010 Definitions. "Department" means the department of social and health services.

"Active parole" means all time served by a JRA youth under JRA parole supervision except that time during which the offender is:

(1) Under a JRA warrant;

(2) Held in detention within or outside the state of Washington pending a parole revocation hearing, pending charges or pending a civil commitment hearing under chapter 71.09 RCW;

(3) Serving a term of confinement for a parole revocation;

(4) Placed on seventy-two hour hold status pursuant to RCW 13.40.050;

(5) Placed on unauthorized leave status;

(6) Committed involuntarily for mental health or chemical dependency treatment; or

(7) On temporary assignment status to a county juvenile detention center, a county jail, or to a department of corrections facility.

If no other time is concurrently tolled against active parole per (1) through (7) above, one additional day is tolled against active parole when the offender is subject to:

• A parole revocation initiated by the JRA.

• A seventy-two hour hold in a JRA facility pending a parole revocation hearing.

"Confinement" means electronic monitoring of a juvenile or physical custody of a juvenile:

• By the department of social and health services in a facility operated by or pursuant to a contract with the juvenile rehabilitation administration;

• In a county detention facility as defined in RCW 13.40.020 or in a county jail;

• In a facility operated by the department of corrections under provisions of RCW 13.40.280 or 13.40.285; or

• In another state under terms of chapter 13.24 RCW and of the interstate compact to which the state of Washington is a party.

"Detention" means, for purposes of this rule, temporary confinement of a juvenile pending charges, court disposition or administrative hearing.

"Juvenile parole officer" means a state employee, or person under contract to the state, whose responsibilities include supervising juvenile parolees.

"Juvenile parolee" means a person under age twenty-one released from a juvenile rehabilitation administration residential facility and placed under the supervision of a juvenile parole officer.

"Modification of parole conditions" means a change in the "order of parole conditions" provided by the juvenile parole officer with full knowledge of the change by the juvenile parolee.

"Parole" means a period of supervision following release from a juvenile rehabilitation administration residential facility, during which time certain parole conditions are to be followed.

"Parole conditions" mean interventions or expectations that include, but are not limited to, those listed in RCW 13.40.210, intended to facilitate the juvenile parolee's reinte-

gration into the community and/or to reduce the likelihood of reoffending.

"Secretary" means secretary of the department of social and health services or his/her designee.

"Violation" means behavior by a juvenile parolee contrary to written parole conditions which may result in sanctions that include, but are not limited to, modification of parole conditions and/or confinement.

"Target victim population" means persons who, by age, sex, race, ethnicity, body conformation or coloration or other personal characteristics are consistent with those of a JRA youth's known victim(s).

[Statutory Authority: RCW 13.40.210 (4)(b). 08-21-038, § 388-740-0010, filed 10/8/08, effective 11/8/08. Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, amended and recodified as § 388-740-0010, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-010, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-010, filed 10/5/88.]

WAC 388-740-0030 Parole arrest warrant. (1) A juvenile parole officer:

(a) Must issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The parole arrest warrant, on department forms, must include a statement of the nature of the violation(s) and the date it occurred.

(3) A juvenile parolee held in detention for an alleged violation of parole conditions is entitled to an informal hearing to determine whether there is probable cause to believe a parole violation occurred and whether continued detention pending a parole revocation hearing is necessary. The hearing must be:

(a) Held within twenty-four hours (excluding Saturdays, Sundays, and holidays) of being placed in detention for an alleged violation of parole conditions; and

(b) Conducted by a parole supervisor or designee not directly involved in the case. The parole supervisor or designee must:

(i) Interview both the juvenile parolee and a juvenile parole staff with knowledge of the alleged violation(s). If such a parole staff is unavailable, documentation of the allegation(s) may be reviewed in place of the staff interview; and

(ii) Issue a decision, immediately following the hearing, with reasons for either releasing the juvenile parolee or authorizing continued detention. The decision must be documented on department forms. In no event shall a juvenile parolee be held in detention for an alleged violation of parole conditions longer than seventy-two hours (excluding Saturdays, Sundays, and holidays) without a parole revocation petition being filed pursuant to WAC 275-30-040.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0030, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-030, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-030, filed 10/5/88.]

WAC 388-740-0040 Parole revocation petition. (1) The juvenile parole officer:

(a) Must initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon. Criteria in WAC 388-740-0070 (2), (3), (4) and (5) are assessed by the juvenile parole officer to determine the type of revocation and duration of confinement for which to petition.

(2) The petition, on department forms, must include:

(a) A statement of the nature of the violation and the date it occurred;

(b) The relief requested by the juvenile parole officer as a result of the violation;

(c) Notice of the juvenile parolee's right to be represented by an attorney, either one of his/her own choosing or one appointed at public expense;

(d) A parole revocation hearing waiver agreement;

(e) The dated signature of the regional administrator or designee; and

(f) If the parole revocation hearing is not waived, notice of the time, date, and location of the parole revocation hearing and notice that failure to appear may result in default.

(3) An initial copy of the petition that includes the information described in subsection (2)(a) through (e) must:

(a) Be provided to the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible, and in accordance with laws and rules governing the release of confidential information. The juvenile parole officer must document the date and time he/she provided the initial copy of the petition to the juvenile parolee or the juvenile parolee's attorney.

(4) A juvenile parolee, only through an attorney, may waive the right to a parole revocation hearing and agree to the parole revocation and agreed upon relief. The decision to waive must be documented with dated signatures on the original petition.

(5) If the juvenile parolee through his/her attorney does not waive the right to a hearing, the parole revocation petition must be filed with the local office of the state office of administrative hearings within seventy-two hours (excluding Saturdays, Sundays, and holidays) of:

(a) The juvenile parolee being placed in detention for an alleged violation of parole conditions; or

(b) The juvenile parolee or his/her attorney being provided with a copy of the petition under subsection (3) of this section if the juvenile parolee is not detained.

(6) The filed petition must include notice that failure to appear may result in default, and the time, date, and location of the parole revocation hearing, as determined by the state office of administrative hearings. A copy of the filed petition must:

(a) Be served either personally or by certified mail, return receipt requested, on the juvenile parolee or the juvenile parolee's attorney; and

(b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible, and in accordance with laws and rules governing the release of confidential information.

[Statutory Authority: RCW 13.40.210 (4)(b). 08-21-038, § 388-740-0040, filed 10/8/08, effective 11/8/08. Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0040, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-040, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-040, filed 10/5/88.]

WAC 388-740-0060 Parole revocation hearing. (1) After the petition is filed a parole revocation hearing must be held to determine whether the alleged parole violation occurred unless the juvenile parolee waives his/her right to a parole revocation hearing. If the juvenile parolee is held in detention as described under WAC 275-30-030, the administrative law judge must hold the hearing within seventy-two hours (excluding Saturdays, Sundays, and holidays) of the petition being served. Otherwise the administrative law judge must hold a hearing no sooner than seven days after the petition is served, but no later than fourteen days after the petition is served.

(2) At the parole revocation hearing, the juvenile may waive the right to be represented by an attorney. A juvenile waiving the right to an attorney may either contest or agree to the parole revocation.

(3) The administrative law judge must:

(a) Conduct a parole revocation hearing in accordance with chapter 10-08 WAC except as otherwise indicated in these rules;

(b) Grant the parole revocation petition if the administrative law judge finds, by a preponderance of the evidence, the violation occurred and the violation warrants revocation;

(c) Order the relief requested in the petition, if the parole revocation petition is granted;

(d) Issue an oral decision immediately following the parole revocation hearing;

(e) Issue a written decision within forty-eight hours of the hearing; and

(f) Provide a copy of the decision to the juvenile parole officer, the juvenile parolee and his/her attorney, the juvenile parolee's parent/guardian, and the department. The administrative law judge's decision shall constitute a final administrative decision.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0060, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-060, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-060, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-060, filed 10/5/88.]

WAC 388-740-0070 Confinement. (1) Mandatory confinement.

A JRA youth must be confined for a minimum of thirty days for possession of a firearm or use of a deadly weapon while on parole, per RCW 13.40.210 (4)(c).

(2) Confinement for up to thirty days.

A JRA youth may be confined for a period not to exceed thirty days for violating one or more conditions of parole, per RCW 13.40.210 (4)(a)(i) through (iv).

(3) Confinement for remainder of sentence.

As provided for in RCW 13.40.210 (4)(a)(v) and (vi), certain JRA youth who are placed on parole before completing their maximum sentence may be returned to confinement for the remainder of their sentence if they violate conditions of parole.

(a) Sex Offenders: A JRA youth may be returned to confinement for the remainder of the sentence range if the offense for which the youth was sentenced is rape in the first or second degree, rape of a child in the first or second degree, child molestation in the first degree, indecent liberties with forcible compulsion, or a sex offense that is also a serious violent offense as defined under RCW 9.94A.030.

(i) The remainder of sentence is calculated as the maximum aggregated term of qualifying sex offenses, minus the number of days served on the aggregated sentence for the qualifying sex offense or offenses.

(ii) Previous days in confinement for a parole violation are not deducted in this calculation.

(iii) Aggregated terms are served such that any term or terms for qualifying sex offenses are considered the last served.

(b) Graduates of basic training camp: A JRA youth who has successfully completed the juvenile offender basic training camp program under RCW 13.40.320 may be returned to confinement for the remainder of their sentence range.

(i) The remainder of sentence is calculated as the maximum aggregated term or four hundred fifty-five days, whichever is shorter, minus the number of days served on their aggregated sentence and on active parole.

(ii) Previous days in confinement for a parole violation are not deducted in this calculation.

(4) Juvenile sex offender confinement for up to twenty-four weeks.

(a) As provided for in RCW 13.40.210 (4)(b), a JRA youth may be returned to confinement for up to twenty-four weeks if:

(i) The JRA youth was sentenced for a sex offense as defined in RCW 9A.44.130;

(ii) The JRA youth is known to have violated the terms of parole; and

(iii) In the determination of the secretary, other graduated sanctions or interventions have not been effective in controlling the youth's parole violations; or

(iv) The behavior is so egregious it warrants the use of the higher level intervention and the violation:

(A) Is a known pattern of behavior consistent with a previous sex offense that puts the JRA youth at high risk for reoffending sexually;

(B) Consists of sexual behavior that is determined to be predatory as defined in RCW 71.09.020; or

(C) Requires a review under chapter 71.09 RCW, due to a recent overt act.

(b) The total number of days of confinement under subsection (4) shall not exceed the number of days provided by the maximum sentence imposed by the disposition for the underlying sex offense or offenses pursuant to RCW 13.40.-0357.

(c) The department shall not aggregate multiple parole violations that occur prior to the parole revocation hearing and impose consecutive twenty-four week periods of confinement for each parole violation under subsection (4).

(5) Criteria for juvenile sex offender confinement.

A parole revocation petition to confine a juvenile sex offender for the remainder of sentence under subsection (3) or for up to twenty-four weeks under subsection (4) will be based on, but not limited to, the following behavioral and sentence considerations:

(a) Behavioral criteria:

(i) Behavior that appears to constitute a new sex offense or a statement by the JRA youth reporting a new sex offense;

(ii) Statements by the JRA youth that he/she is at imminent risk to re-offend sexually unless confined;

(iii) Accessing, making or possessing child pornography;

(iv) Accessing, making or possessing pornography that depicts excessive physical violence, death or threats of death, torture or infliction of pain, use of a weapon, humiliation or bondage;

(v) Possession of materials which, in total, constitute a "rape kit";

(vi) Unsupervised contact with previous victim(s) or target victim populations, except for approved peer age contact (attending school, etc.);

(vii) Use, possession or providing of drugs and/or alcohol associated with the JRA youth's illegal sexualized behaviors.

(b) Available remainder of sentence range.

If the JRA youth has not served the maximum sentence imposed for the underlying offense or offenses, and confinement under WAC 388-740-0070 (3) or (4) are both available, the petition for relief will take into account whether the remainder of sentence is sufficient to accomplish the purposes of the revocation. If so, the petition will be for confinement for the remainder of the sentence range; if not, the petition will be for up to twenty-four weeks of confinement.

(6) If the JRA youth's parole is revoked, the department must give the youth credit against any period of confinement for days served in detention pending the parole revocation hearing.

(7) Serving confinement.

(a) The JRA youth must serve his or her confinement in a facility or detention facility as described in WAC 388-740-0010.

(b) Confinement may be continuous, or for a portion of each day, or for certain days each week with the balance of time under supervision.

(8) If a juvenile's parole is revoked two or more times during one parole period, the secretary must approve any period of confinement exceeding a combined total of thirty days.

(9) Unless conditions of parole are otherwise amended, the order of parole conditions in effect at the time the parole was revoked shall be deemed reinstated immediately following any period of confinement.

[Statutory Authority: RCW 13.40.210 (4)(b). 08-21-038, § 388-740-0070, filed 10/8/08, effective 11/8/08. Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0070, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-070, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-070, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-070, filed 10/5/88.]

Chapter 388-745 WAC

TRANSFER OF JUVENILE OFFENDER TO THE DEPARTMENT OF CORRECTIONS

(Formerly chapter 275-33 WAC)

WAC

WAC 388-745-020 Notification to juvenile. A juvenile being considered for transfer to DOC shall be notified in writing at least five days in advance of the review board hearing convened to consider the matter. Notification to the juvenile offender will include the reasons the transfer is being considered and a copy of the rules pertaining to the review board hearing. Prior to any review board hearing, the juvenile being considered for transfer to DOC, or the juvenile's attorney, shall have the right of access to, and adequate opportunity to examine any files or records of the department pertaining to the proposed transfer of the juvenile to the department of corrections.

[00-16-078, recodifed as § 388-745-020, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-020, filed 4/30/84.]

WAC 388-745-030 Composition of board. The review board will be composed of the director of DJR or designee and two other juvenile rehabilitation administrators appointed by the chairman.

[00-16-078, recodifed as § 388-745-030, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-030, filed 4/30/84.]

WAC 388-745-040 Attendance at hearing. Attendance at a review board shall be limited to parties directly concerned. The chairperson may exclude unauthorized persons unless the parties agree to their presence. Parties shall have the right to present evidence, cross-examine witnesses and make recommendations to the board. All relevant and material evidence is admissible which, in the opinion of the chairperson, is the best evidence reasonably obtainable, having due regard for its necessity, availability and trustworthiness.

[00-16-078, recodifed as § 388-745-040, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-040, filed 4/30/84.]

WAC 388-745-050 Consideration of evidence. At the conclusion of the hearing, the review board will consider all evidence presented and make a decision whether continued placement of the juvenile offender in an institution for juvenile offenders presents a continuing and serious threat to the safety of others in the institution.

[00-16-078, recodified as § 388-745-050, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-050, filed 4/30/84.]

WAC 388-745-060 Record of decision. The chair of the review board will prepare a written record of the decision and reasons therefore. The review board shall be recorded

manually, or by mechanical, electronic, or other device capable of transcription.

[00-16-078, recodified as § 388-745-060, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-060, filed 4/30/84.]

Chapter 388-750 WAC

IMPACT ACCOUNT—CRIMINAL JUSTICE COST REIMBURSEMENT

WAC

WAC 388-750-010 Definitions. The following words and phrases shall have the following meaning when used in these regulations regarding the interpretation of regulations for the reimbursement from impacts caused by criminal behavior of state institutional residents:

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

"Incremental" means efforts or costs incurred by cities, towns, and/or counties that are not otherwise incurred and are only as a result of the criminal behavior of state institutional residents.

"Resident" means any person committed to a state institution by the courts for confinement as an offender pursuant to chapters 10.64, 10.77, and 13.40 RCW.

"Institution" means any state institution operated by the department for the confinement of offenders committed under chapters 10.64, 10.77, and 13.40 RCW.

"Law enforcement cost" means costs incurred to apprehend escapees or to investigate crimes committed by institutional residents within or outside state institutions listed in this chapter.

"Resident" means any person committed to a state institution by the courts for confinement as an offender under chapters 10.64, 10.77, and 13.40 RCW.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-010, filed 11/14/00, effective 12/15/00.]

WAC 388-750-020 Limitation of funds. The secretary shall make reimbursement to the extent funds are available. Reimbursement shall be strictly limited to political subdivisions in which state institutions, as defined in WAC 388-750-030, are located. Only incremental costs directly, specifically, and exclusively associated with criminal activities of offenders who are residents of state institutions shall be considered for reimbursement. Reimbursement shall be restricted to fully documented law enforcement, prosecutorial, judicial, and jail facilities costs. No such costs shall be paid under these rules if they are reimbursable under other chapters of the Washington Administrative Code. During each biennium, claims for incidents which occurred during the biennium will be paid in the order in which they are received until the biennial appropriation is fully expended.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-020, filed 11/14/00, effective 12/15/00.]

WAC 388-750-030 Institutions and eligible impacted political subdivisions. Reimbursement shall be limited to the following city, town, and county governments impacted by the offenses from residents committed to institutions listed in this section.

Institution	Cities/County
(1) Echo Glen Children's Center	Snoqualmie/King
(2) Green Hill Training School	Chehalis/Lewis
(3) Maple Lane School	Rochester/Thurston
(4) Mission Creek Youth Camp	Belfair/Mason
(5) Naselle Youth Camp	Naselle/Pacific
(6) Woodinville Treatment Center	Woodinville/King
(7) Canyon View Community Facility	East Wenatchee/Douglas
(8) Sunrise Community Facility	Ephrata/Grant
(9) Twin Rivers Community Facility	Richland/Benton
(10) Oakridge Community Facility	Tacoma/Pierce
(11) Park Creek Treatment Center	Kittitas/Kittitas
(12) Ridgeview Community Facility	Yakima/Yakima
(13) Western State Hospital	Steilacoom/Pierce
(14) Eastern State Hospital	Medical Lake/Spokane/ Spokane
(15) Child Study and Treatment Center	Steilacoom/Pierce

(16) For any institution not listed in this section, reimbursement shall be limited to the political subdivisions where the institution is located. The institutions include juvenile community facilities, community treatment and community care facilities, as defined in WAC 388-750-010.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-030, filed 11/14/00, effective 12/15/00.]

WAC 388-750-040 Maximum allowable reimbursement for law enforcement costs. The department shall limit reimbursement to the specific political subdivisions listed in WAC 388-750-030. The maximum reimbursement rates shall be twenty-three dollars and ninety-six cents per hour. These reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-040, filed 11/14/00, effective 12/15/00.]

WAC 388-750-050 Maximum allowable reimbursement for prosecutorial costs. The department shall reimburse claims, at the rate set forth in WAC 388-750-040, for pretrial investigations of crimes committed inside or outside institutions, to the political subdivision courts in WAC 388-750-040. If, after investigation, criminal charges are filed, the department may reimburse documented prosecutorial and defense attorney fees. Reimbursement shall not exceed the following rates for each attorney, reimbursement includes costs for paralegals: Fifty-seven dollars and thirty-two cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-050, filed 11/14/00, effective 12/15/00.]

WAC 388-750-060 Maximum allowable reimbursement for judicial costs. (1) The department shall limit judicial costs strictly to cases involving inmates of institutions listed in WAC 388-750-030 and the listed subdivision in which they reside. Reimbursement shall be limited to judges, court reporters, transcript typing, and witness and jury fees.

(2) The department shall reimburse judges hearing cases including services provided by court clerks and bailiffs at fifty-seven dollars and thirty-two cents per hour. Reimburse court reporters at the rate of twenty-four dollars and seventy-one cents per hour. Reimburse for the typing of transcripts at four dollars and seventy-nine cents per page. If required, reimburse expert witnesses at eighty dollars and forty-three cents per hour.

(3) Reimbursement for witness fees (other than experts) and jury fees shall be at the rate established by the local governmental legislative authority but not in excess of thirty-six dollars and eleven cents per day.

(4) These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-060, filed 11/14/00, effective 12/15/00.]

WAC 388-750-070 Maximum allowable reimbursement for jail facilities. The department shall limit jail facility cost reimbursement strictly to incremental costs as defined in WAC 388-750-010. Requests for reimbursement shall be fully documented and shall include the resident's name and all appropriate admission and release dates. Limit reimbursement to thirty-four dollars and eighty cents per resident day. The department shall not reimburse for costs incurred for holding persons regarding parole revocations or for holding persons involved in civil litigation. The department shall reimburse costs of providing security when residents require hospitalization at the rate of fourteen dollars and nineteen cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-070, filed 11/14/00, effective 12/15/00.]

WAC 388-750-080 Billing procedure. Requests for reimbursement should be made on the standard Washington State Invoice Voucher, Form A19, with supporting documentation attached. All claims may be subject to periodic audits at the discretion of the secretary, per WAC 388-750-110.

(1) All requests for reimbursement under this section shall note the name of the offender for whom costs were incurred, and the institution to which the offender was assigned.

(2) Requests for reimbursement may only be submitted by the jurisdiction's responsible fiscal officer, e.g., city manager, city supervisor, county auditor, county administrator, etc.

(3) All requests for reimbursement must be submitted to: DSHS and the pertinent Accounts Payable Section of either Juvenile Rehabilitation Administration, Mailstop 45720, Olympia, Washington 98504; or Mental Health Division, Mail Stop 45320, Olympia, Washington 98504.

(4) If the appropriation for a biennium is fully expended prior to the end of the biennium, political subdivisions should continue to submit claims for the purpose of providing justification for requests for adequate funding levels in future biennia.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-080, filed 11/14/00, effective 12/15/00.]

WAC 388-750-090 Exceptions. The secretary, of the department, may allow exceptions to these rules.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-090, filed 11/14/00, effective 12/15/00.]

WAC 388-750-100 Effective date. Claims submitted according to this chapter may only be for costs incurred for appropriate actions, as defined in this chapter, taken by criminal justice agencies on or after August 30, 1979.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-100, filed 11/14/00, effective 12/15/00.]

WAC 388-750-110 Audits. The department has the right to audit any or all claims.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-110, filed 11/14/00, effective 12/15/00.]

Chapter 388-800 WAC

CHEMICAL DEPENDENCY ASSISTANCE PROGRAMS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

WAC 388-800-0005 What is the purpose of this chapter? This chapter explains chemical dependency treatment services available through public assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0005, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0020 What detoxification services will the department pay for? (1) The department only pays for services that are:

(a) Provided to eligible persons (see WAC 388-800-0030);

(b) Directly related to detoxification; and

(c) Performed by a certified detoxification center or by a general hospital that has a contract with the department to provide detoxification services.

(2) The department limits on paying for detoxification services are:

(a) Three days for an acute alcoholic condition; or

(b) Five days for acute drug addiction.

(3) The department only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0020, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0025 What information does the department use to decide if I am eligible for the detoxification program? (1) The department uses the information you provide on the department's application form to determine if you are eligible for the detoxification program.

(2) The department may require an interview, documents or other verification if the department has questions about or needs to confirm the information you provided on your application.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0025, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0030 Who is eligible for detoxification services? (1) You are eligible for detoxification services if you:

(a) Receive benefits from temporary aid for needy families (TANF), general assistance unemployable (GAU), a medical assistance program, or Supplemental Security Income (SSI); or

(b) Do not have a combined nonexempt income and/or resources that exceed the payment standards for TANF.

(2) To determine your financial eligibility for the detoxification program the department deducts or exempts the following:

(a) A home;

(b) Household furnishings and personal clothing essential for daily living;

(c) Other personal property used to reduce need for assistance or for rehabilitation;

(d) A used and useful automobile;

(e) Mandatory expenses of employment;

(f) Total income and resources of a noninstitutionalized SSI beneficiary;

(g) Support payments paid under a court order; and

(h) Payments to a wage earner plan specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(3) The following resources are not exempt:

(a) Cash;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(4) If you receive detoxification services you shall not incur a deductible as a factor of eligibility for the covered period of detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0030, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0035 How long am I eligible to receive detoxification services? You are eligible for detoxification services from the date detoxification begins through the end of the month in which you complete the detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0035, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0040 What is ADATSA? (1) ADATSA stands for the Alcohol and Drug Addiction Treatment and Support Act which is a legislative enactment providing state-financed treatment and support to chemically dependent indigent persons.

(2) ADATSA provides eligible people with:

(a) Treatment if you are chemically dependent and would benefit from it; or

(b) A program of shelter services if you are chemically dependent and your chemical dependency has resulted in incapacitating physiological or cognitive impairments.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0040, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0045 What services are offered by ADATSA? If you qualify for the ADATSA program you may be eligible for:

(1) Alcohol/drug treatment services and support described under WAC-388-800-0080.

(2) Shelter services as described under WAC 388-800-0130.

(3) Medical care services as described under WAC 388-556-0500, 388-501-0060, and 388-501-0065.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-800-0045, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0045, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0045, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0048 Who is eligible for ADATSA? To be eligible for ADATSA services you must:

(1) Be eighteen years of age or older;

(2) Be a resident of Washington as defined in WAC 388-468-0005;

(3) Meet citizenship requirements as described in WAC 388-424-0015(3).

(4) Provide your Social Security number; and

(5) Meet the same income and resource criteria for the GA-U program; OR be receiving federal assistance under SSI or TANF.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-800-0048, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0048, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0050 When am I eligible for ADATSA treatment services? (1) You are eligible for ADATSA treatment services when you meet the:

(a) Financial eligibility criteria in WAC 388-800-0048; and

(b) Incapacity eligibility criteria in WAC 388-800-0055.

(2) If you are able to access, at no cost, state-approved chemical dependency treatment comparable to ADATSA treatment services, you may choose it rather than ADATSA.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0050, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0055 What clinical incapacity must I meet to be eligible for ADATSA treatment services? You are clinically eligible for ADATSA treatment services when you:

(1) Are diagnosed as having a mild, moderate, or severe dependency on a psychoactive substance class other than nicotine or caffeine, using the current criteria for Psychoactive Substance Dependence in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM IV or its successor);

(2) Have not abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated;

(3) Have not been gainfully employed in a job in the competitive labor market at any time during the last thirty days. For the purposes of this chapter, "gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job; and

(4) Are incapacitated, i.e., unable to work. Incapacity exists if you are one or more of the following:

(a) Currently pregnant or up to two months postpartum;

(b) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services;

(c) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user;

(d) Diagnosed as severely psychoactive substance dependent and has at least one prior admission to a department-approved alcohol/drug treatment or detoxification program;

(e) Diagnosed as severely psychoactive substance dependent and have had two or more arrests for offenses directly related to the chemical dependency; or

(f) Lost two or more jobs during the last six months as a direct result of chemical dependency.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0055, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0055, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0057 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse? When you are successfully participating in ADATSA outpatient treatment services you are still considered incapacitated and eligible for ADATSA treatment through completion of the planned treatment, even if you:

(1) Become employed;

(2) Abstain from alcohol or drug use; or

(3) Relapse (resumption of your psychoactive substance abuse dependence).

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0057, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0060 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility? (1) A department-certified chemical dependency service provider determines your clinical incapacity based on alcoholism and/or drug addiction.

(2) The certified chemical dependency service provider provides a written current assessment needed to determine your eligibility.

(3) This assessment is the department's sole source of medical evidence required for the diagnosis and evaluation of your chemical dependency and its effects on employability.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0060, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0060, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0065 What are the responsibilities of the certified chemical dependency service provider in determining eligibility? (1) The role of the certified chemical dependency service provider is to:

(a) Provide your diagnostic evaluation and decide your initial treatment placement;

(b) Conduct a face-to-face diagnostic assessment, according to WAC 388-805-310, to determine if you:

(i) Are chemically dependent;

(ii) Meet incapacity standards for treatment under WAC 388-800-0055; and

(iii) Are willing, able, and eligible to undergo a course of ADATSA chemical dependency treatment, once determined incapacitated.

(c) Determines a course of treatment based on your individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0065, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0065, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0070 What happens after I am found eligible for ADATSA services? Once your financial and clinical eligibility is established, the certified chemical dependency service provider:

(1) Develops your ADATSA treatment plan;

(2) Arranges your initial chemical dependency treatment placements taking into account the treatment priorities described under WAC 388-800-0100;

(3) Provides you with written notification of your right to return to the community service office (CSO) at any time while receiving ADATSA treatment;

(4) Provides you with written notification of your right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment; and

(5) Notifies the CSO promptly of your placement or eligibility status changes.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0070, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0070, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0075 What criteria does the certified chemical dependency service provider use to plan my treatment? When evaluating a treatment plan which will benefit you the most, the certified chemical dependency service provider considers clinical or medical factors utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC).

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0075, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0075, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0085 Do I have to contribute to the cost of residential treatment? Once you have been determined financially eligible to receive ADATSA residential treatment services the department does not require you to contribute toward the cost of care.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0085, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0090 What happens when I withdraw or am discharged from treatment? (1) You will be terminated from ADATSA treatment services if you leave treatment.

(2) If you are discharged from treatment for any other reason, you will be referred to the next appropriate level of treatment.

(3) If you are absent from any residential treatment services for less than seventy-two hours you may reenter that program without being considered as having dropped out. This is done at the discretion of the treatment service administrator and without requiring you to apply for readmittance through the certified chemical dependency service provider.

(4) Once you voluntarily leave treatment you must reapply and be referred again to the certified chemical dependency service provider to receive further ADATSA treatment services.

(5) If you are terminated from treatment you are not eligible for benefits beyond the month in which treatment services end. Rules regarding advance and adequate notice still apply, but you are not eligible for continued assistance pending a fair hearing.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0090, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0090, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0100 What are the groups that receive priority for ADATSA services? (1) When assigning treatment admissions, the ADATSA/Adult assessment certified chemical dependency service provider:

(a) Gives first priority to you if you are a pregnant woman or a parent with a child under eighteen years old in the home;

(b) Provides priority access for admission if you are:

(i) Referred by the department's children's protective services (CPS) program; and/or

(ii) An injecting drug user (IDU).

(2) If you are completing residential treatment you have priority access to outpatient treatment.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0100, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0100, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0110 What cash benefits am I eligible for through ADATSA if I am in residential treatment? When you are in ADATSA residential treatment and are below the department payment standard for clothing and personal incidentals (CPI) you may be eligible to receive CPI.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0110, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.-090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0110, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0115 What cash benefits can I receive through ADATSA if I am in outpatient treatment? When you are in ADATSA outpatient treatment, you may be eligible for a treatment living allowance for housing and other living expenses.

(1) Your living allowance maximum amount will be based on the current ADATSA payment standard as provided under WAC 388-478-0030.

(2) Your outpatient provider will act as your protective payee and administer your living allowance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0115, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0120 As an eligible ADATSA client, when would I get state-funded medical assistance? You are eligible for state-funded medical assistance when you are in one of the following situations:

(1) You meet the requirements in WAC 388-800-0048 and are waiting to receive ADATSA treatment services;

(2) When you are participating in ADATSA residential or outpatient treatment;

(3) You choose opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program; or

(4) You meet the requirements of WAC 388-800-0135, for shelter services but choose not to receive shelter assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0120, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0130 What are ADATSA shelter services? (1) Your shelter assistance in independent housing consists of a monthly shelter assistance payment through an intensive protective payee defined under WAC 388-800-0160; and

(2) You continue to receive benefits for ADATSA shelter if you request a fair hearing within the advance notice period before termination is to occur.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0130, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0135 When am I eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you meet the:

(1) Financial eligibility criteria in WAC 388-800-0040; and

(2) Incapacity eligibility criteria in WAC 388-800-0140.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0135, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0140 What incapacity criteria must I meet to be eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you:

(1) Are actively addicted, meaning having used alcohol or drugs within the sixty-day period immediately preceding the latest assessment center evaluation, as determined by the ADATSA/Adult assessment center; and

(2) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate within sixty days of sobriety or detoxification, which either:

(a) Limits your functioning because of physiological or organic damage that result in a significant restriction on ability to perform work activities, or

(b) At least a moderate impairment of your ability to understand, remember, and follow complex instructions; and

(c) An overall moderate impairment in your ability to:

(i) Learn new tasks;

(ii) Exercise judgment;

(iii) Make decisions, and

(iv) Perform routine tasks without undue supervision.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0140, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0145 How does the department review my eligibility for ADATSA shelter services? The department:

(1) Redetermines your incapacity and financial and medical eligibility for ADATSA shelter every six months or more often; and

(2) Provides you adequate and advance notice of adverse action.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0145, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0150 Who is my protective payee? Your protective payee is either:

(1) Your outpatient treatment provider while in ADATSA treatment; or

(2) An agency under contract with the department to provide you with intensive protective payee services if you are an ADATSA shelter client.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0150, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0155 What are the responsibilities of my protective payee? Your protective payee:

(1) Has the authority and responsibility to make decisions about the expenditure of your outpatient treatment stipends;

(2) Encourages you to participate in the decision-making process. The amount of decision making the protective payee allows you depends upon the level of responsibility you demonstrate; and

(3) Disburses funds to meet your basic needs of shelter, utilities, food, clothing, and personal incidentals.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0155, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0160 What are the responsibilities of an intensive protective payee? If you are receiving shelter services, your intensive protective payee provides you with case management services including, but not be limited to:

(1) Disbursing payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc.;

(2) Directing payment to vendors directly for goods or services provided to you including personal and incidental expenses.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0160, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0165 What happens if my relationship with my protective payee ends? If the relationship with your protective payee is terminated for any reason, the protective payee shall return any remaining funds to the department or its designee.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0165, filed 7/28/00, effective 9/1/00.]

Chapter 388-805 WAC

CERTIFICATION REQUIREMENTS FOR CHEMICAL DEPENDENCY SERVICE PROVIDERS

(Formerly chapter 440-22 WAC)

WAC

SECTION I—PURPOSE AND DEFINITIONS

SECTION II—APPLICATION FOR CERTIFICATION

SECTION III—CERTIFICATION FEES

SECTION IV—MAINTAINING CERTIFICATION

SECTION V—ORGANIZATIONAL STANDARDS

SECTION VI—HUMAN RESOURCE MANAGEMENT

SECTION VII—PROFESSIONAL PRACTICES

SECTION VIII—OUTCOMES EVALUATION

SECTION IX—PROGRAM SERVICE STANDARDS

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-805-815 What are the requirements for DUI assessment services? [Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-815, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-815, filed 11/21/00, effective 1/1/01.] Repealed by 08-24-083, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.-040, chapter 70.96A RCW, and 42 C.F.R. Part 8.

388-805-850 What are the requirements for treatment accountability for safer communities (TASC) providers and services? [Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-850, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-850, filed 11/21/00, effective 1/1/01.] Repealed by 06-11-096, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.-090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8.

388-805-900 What are the requirements for outpatient child care when a parent is in treatment? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-900, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-905 What are the requirements for outpatient child care admission and health history? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-905, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-910 What are the requirements for outpatient child care policies? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-910, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-915 What are the requirements for an outpatient child care activity program? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-915, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-920 What are the requirements for outpatient child care behavior management and discipline? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-920, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.-090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-925 What are the requirements for outpatient child care diaper changing? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-925, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-930 What are the requirements for outpatient child care food service? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-930, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-935 What are the staffing requirements for outpatient child care services? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-935, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

SECTION I—PURPOSE AND DEFINITIONS

WAC 388-805-001 What is the purpose of this chapter? These rules describe the standards and processes necessary to be a certified chemical dependency treatment program. The rules have been adopted under the authority and purposes of the following chapters of law.

(1) Chapter 10.05 RCW, Deferred prosecution—Courts of limited jurisdiction;

(2) Chapter 46.61 RCW, Rules of the road;

(3) Chapter 49.60 RCW, Discrimination—Human rights commission;

(4) Chapter 70.96A RCW, Treatment for alcoholism, intoxication and drug addiction; and

(5) Chapter 74.50 RCW, Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-001, filed 11/21/00, effective 1/1/01.]

WAC 388-805-005 What definitions are important throughout this chapter? "Added service" means the adding of certification for chemical dependency levels of care to an existing certified agency at an approved location.

"Addiction counseling competencies" means the knowledge, skills, and attitudes of chemical dependency counselor professional practice as described in Technical Assistance Publication No. 21, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services 1998.

"Administrator" means the person designated responsible for the operation of the certified treatment service.

"Adult" means a person eighteen years of age or older.

"Alcoholic" means a person who has the disease of alcoholism.

"Alcoholism" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Approved supervisor" means a person who meets the education and experience requirements described in WAC 246-811-030 and 246-811-045 through 246-811-049 and who is available to the person being supervised.

"Authenticated" means written, permanent verification of an entry in a patient treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If patient records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a patient's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

(1) Full printed name;

(2) Signature including the first initial and last name; and

(3) Initials and abbreviations indicating professional designation or job title.

"Bloodborne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

"Branch site" means a physically separate certified site where qualified staff provides a certified treatment service, governed by a parent organization. The branch site is an extension of a certified provider's services to one or more sites.

"Certified treatment service" means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the department of social and health services, as evidence the provider meets the standards of chapter 388-805 WAC.

"Change in ownership" means one of the following conditions:

(1) When the ownership of a certified chemical dependency treatment provider changes from one distinct legal owner to another distinct legal owner;

(2) When the type of business changes from one type to another such as, from a sole proprietorship to a corporation; or

(3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

"Chemical dependency" means a person's alcoholism or drug addiction or both.

"Chemical dependency counseling" means face-to-face individual or group contact using therapeutic techniques that are:

(1) Led by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP;

(2) Directed toward patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and

(3) Directed toward a goal of abstinence for chemically dependent persons.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

"Child" means a person less than eighteen years of age, also known as adolescent, juvenile, or minor.

"Clinical indicators" include, but are not limited to, inability to maintain abstinence from alcohol or other nonprescribed drugs, positive drug screens, patient report of a subsequent alcohol/drug arrest, patient leaves program against program advice, unexcused absences from treatment, lack of participation in self-help groups, and lack of patient progress in any part of the treatment plan.

"Community relations plan" means a plan to minimize the impact of an opiate substitution treatment program as defined by the Center for Substance Abuse Guidelines for the Accreditation of Opioid Treatment Programs, section 2.C. (4).

"County coordinator" means the person designated by the legislative authority of a county to carry out administrative and oversight responsibilities of the county chemical dependency program.

"Criminal background check" means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.

"Critical incidents" includes:

(1) Death of a patient;

(2) Serious injury;

(3) Sexual assault of patients, staff members, or public citizens on the facility premises;

(4) Abuse or neglect of an adolescent or vulnerable adult patient by another patient or agency staff member on facility premises;

(5) A natural disaster presenting a threat to facility operation or patient safety;

(6) A bomb threat; a break in or theft of patient identifying information;

(7) Suicide attempt at the facility;

(8) An error in program administered medication at an outpatient facility that results in adverse effects requiring urgent medical intervention.

"CSAT" means the Federal Center For Substance Abuse Treatment, a Substance Abuse Service Center of the Substance Abuse and Mental Health Services Administration.

"Danger to self or others," for purposes of WAC 388-805-520, means a youth who resides in a chemical dependency treatment agency and creates a risk of serious harm to the health, safety, or welfare to self or others. Behaviors considered a danger to self or others include:

(1) Suicide threat or attempt;

(2) Assault or threat of assault; or

(3) Attempt to run from treatment, potentially resulting in a dangerous or life-threatening situation.

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

"Determination of need" means a process used by the department for opiate substitution treatment program slots within a county area as described in WAC 388-805-040.

"Detoxification" or **"detox"** means care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Disability, a person with" means a person whom:

(1) Has a physical or mental impairment that substantially limits one or more major life activities of the person;

(2) Has a record of such an impairment; or

(3) Is regarded as having such an impairment.

"Discrete treatment service" means a chemical dependency treatment service that:

(1) Provides distinct chemical dependency supervision and treatment separate from any other services provided within the facility;

(2) Provides a separate treatment area for ensuring confidentiality of chemical dependency treatment services; and

(3) Has separate accounting records and documents identifying the provider's funding sources and expenditures of all funds received for the provision of chemical dependency treatment services.

"Domestic violence" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking as defined in RCW 9A.46.110 of one family or household member by another family or household member; or

(4) As defined in RCW 10.99.020, 26.50.010, or other Washington state statutes.

"Drug addiction" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Drug addiction is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Essential requirement" means a critical element of chemical dependency treatment services that must be present in order to provide effective treatment.

"Established ratio" means using 0.7 percent (.007) of a designated county's adult population to determine an estimate for the number of potential patients with an opiate diagnosis in need of treatment services as described in WAC 388-805-040.

"Faith-based organization" means an agency or organization such as a church, religiously affiliated entity, or religious organization.

"First steps" means a program available across the state for low-income pregnant women and their infants. First steps provides maternity care for pregnant and postpartum women and health care for infants and young children.

"Governing body" means the legal entity responsible for the operation of the chemical dependency treatment service.

"HIV/AIDS brief risk intervention (BRI)" means an individual face-to-face interview with a patient, to help that person assess personal risk for HIV/AIDS infection and discuss methods to reduce infection transmission.

"HIV/AIDS education" means education, in addition to the brief risk intervention, designed to provide a person with information regarding HIV/AIDS risk factors, HIV antibody testing, HIV infection prevention techniques, the impact of alcohol and other drug use on risks and the disease process, and trends in the spread of the disease.

"Medical practitioner" means a physician, advanced registered nurse practitioner (ARNP), or certified physician's assistant. ARNPs and midwives with prescriptive authority may perform practitioner functions related only to indicated specialty services.

"Off-site treatment" means provision of chemical dependency treatment by a certified provider at a location where treatment is not the primary purpose of the site; such as in schools, hospitals, or correctional facilities.

"Opiate substitution treatment program" means an organization that administers or dispenses an approved medication as specified in 42 CFR Part 8 for treatment or detoxification of opiate dependence. The agency is:

(1) Certified as an opioid treatment program by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration;

(2) Licensed by the Federal Drug Enforcement Administration;

(3) Registered by the state board of pharmacy;

(4) Accredited by an opioid treatment program accreditation body approved by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration; and

(5) Certified as an opiate substitution treatment program by the department.

"Outcomes evaluation" means a system for determining the effectiveness of results achieved by patients during or following service delivery, and patient satisfaction with those results for the purpose of program improvement.

"Patient" is a person receiving chemical dependency treatment services from a certified program.

"Patient contact" means time spent with a patient to do assessments, individual or group counseling, or education.

"Patient placement criteria (PPC)" means admission, continued service, and discharge criteria found in the patient placement criteria for the treatment of substance-related disorders as published by the American Society of Addiction Medicine (ASAM).

"Probation assessment officer (PAO)" means a person employed at a certified district or municipal court probation assessment service that meets the PAO requirements of WAC 388-805-220.

"Probation assessment service" means a certified assessment service offered by a misdemeanant probation department or unit within a county or municipality.

"Progress notes" are a permanent record of ongoing assessments of a patient's participation in and response to treatment, and progress in recovery.

"Qualified personnel" means trained, qualified staff, consultants, trainees, and volunteers who meet appropriate legal, licensing, certification, and registration requirements.

"Registered counselor" means a person registered by the state department of health as required by chapter 18.19 RCW.

"Relocation" means change in location from one office space to a new office space, or moving from one office building to another.

"Remodeling" means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

"SAMHSA" means the Federal Substance Abuse and Mental Health Services Administration.

"Screening and brief intervention" means: a combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions to enhance patient motivation to change, and make appropriate referral as needed.

"Self-help group" means community based support groups that address chemical dependency.

"Service provider" or **"provider"** means a legally operated entity certified by the department to provide chemical dependency services. The components of a service provider are:

(1) Legal entity/owner;
(2) Facility; and
(3) Staff and services.

"Sexual abuse" means:
(1) Sexual assault;
(2) Incest; or
(3) Sexual exploitation.

"Sexual harassment" means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

(1) Submission to such conduct is made either explicitly or implicitly a term or condition of employment or treatment; or

(2) Such conduct interferes with work performance or creates an intimidating, hostile, or offensive work or treatment environment.

"Substance abuse" means a recurring pattern of alcohol or other drug use that substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.

"Summary suspension" means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

"Supervision" means:
(1) Regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give directions and require change; and
(2) **"Direct supervision"** means the supervisor is on the premises and available for immediate consultation.

"Suspend" means termination of the department's certification of a provider's treatment services for a specified period or until specific conditions have been met and the department notifies the provider of reinstatement.

"TARGET" means the treatment and assessment report generation tool.

"Treatment plan review" means a review of active problems on the patient's individualized treatment plan, the need to address new problems, and patient placement.

"Treatment services" means the broad range of emergency, detoxification, residential, and outpatient services and care. Treatment services include diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other drugs, and intoxicated persons.

"Urinalysis" means analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the department of health:

(1) **"Negative urine"** is a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and

(2) **"Positive urine"** is a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

"Vulnerable adult" means a person who lacks the functional, mental, or physical ability to care for oneself.

"Young adult" means an adult who is eighteen, nineteen, or twenty years old.

"Youth" means a person seventeen years of age or younger.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-005, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-005, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-005, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-005, filed 11/21/00, effective 1/1/01.]

SECTION II—APPLICATION FOR CERTIFICATION

WAC 388-805-010 What chemical dependency services are certified by the department? (1) The department certifies the following types of chemical dependency services:

(a) **Detoxification services,** which assist patients in withdrawing from alcohol and other drugs including:

(i) **Acute detox,** which provides medical care and physician supervision for withdrawal from alcohol or other drugs; and

(ii) **Subacute detox,** which is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

(b) **Residential treatment services,** which provide chemical dependency treatment for patients and include room and board in a twenty-four-hour-a-day supervised facility, including:

(i) **Intensive inpatient,** a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families;

(ii) **Recovery house,** a program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities; and

(iii) **Long-term treatment,** a program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

(c) **Outpatient treatment services,** which provide chemical dependency treatment to patients less than twenty-four hours a day, including:

(i) **Intensive outpatient,** a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families;

(ii) **Outpatient,** individual and group treatment services of varying duration and intensity according to a prescribed plan; and

(iii) **Opiate substitution outpatient treatment,** which meets both outpatient and opiate substitution treatment program service requirements.

(d) **Assessment services,** which include:

(i) **ADATSA assessments,** alcohol and other drug assessments of patients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment; and

(ii) **DUI assessments,** diagnostic services requested by the courts to determine a person's involvement with alcohol and other drugs and to recommend a course of action.

(e) **Information and assistance services,** which include:

(i) **Alcohol and drug information school,** an education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who may have been assessed and do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs;

(ii) **Information and crisis services,** response to persons having chemical dependency needs, by phone or in person;

(iii) **Emergency service patrol,** assistance provided to intoxicated persons in the streets and other public places;

(iv) **Screening and brief intervention services,** a combination of services designed to screen for risk factors that appear to be related to alcohol and other drug use disorders, provide interventions and make appropriate referral as needed. These services may be provided in a wide variety of settings.

(2) The department may certify a provider for more than one of the services listed under subsection (1) of this section when the provider complies with the specific requirements of the selected services.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-010, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-010, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-010, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-010, filed 11/21/00, effective 1/1/01.]

WAC 388-805-015 How do I apply for certification as a chemical dependency service provider? (1) A potential new chemical dependency service provider, referred to as applicant, seeking certification for one or more services, as described under WAC 388-805-010, must:

(a) Request from the department an application packet of information on how to become a certified chemical dependency service provider; and

(b) Obtain a license as a residential treatment facility from the department of health, if planning to offer residential services.

(2) The applicant must submit a completed application to the department that includes:

(a) If the applicant is a sole provider: The name and address of the applicant, and a statement of sole proprietorship;

(b) If the applicant is a partnership: The name and address of every partner, and a copy of the written partnership agreement;

(c) If the applicant is a limited liability company: The name and addresses of its officers, and any owner of five percent or more of the organizational assets, and a copy of the certificate of formation issued by the state of Washington, secretary of state;

(d) If the applicant is a corporation: The names and addresses of its officers, board of directors and trustees, and any owner of five percent or more or the organizational assets, and a copy of the corporate articles of incorporation and bylaws;

(e) A copy of the master business license authorizing the organization to do business in Washington state;

(f) The social security number or Federal Employer Identification Number for the governing organization or person;

(g) The name of the individual administrator under whose management or supervision the services will be provided;

(h) A copy of the report of findings from a criminal background check of any owner of five percent or more of the organizational assets and the administrator;

(i) Additional disclosure statements or background inquiries if the department has reason to believe that offenses, specified under RCW 43.43.830, have occurred since completion of the original application;

(j) The physical location of the facility where services will be provided including, in the case of a location known only by postal route and box numbers, and the street address;

(k) A plan of the premises assuring the chemical dependency treatment service is discrete from other programs, indicating capacities of the location for the proposed uses;

(l) Floor plan showing use of each room and location of:

(i) Windows and doors;

(ii) Restrooms;

(iii) Floor to ceiling walls;

(iv) Areas serving as confidential counseling rooms;

(v) Other therapy and recreation areas and rooms;

(vi) Confidential patient records storage; and

(vii) Sleeping rooms, if a residential facility.

(m) A completed facility accessibility self-evaluation form;

(n) Policy and procedure manuals specific to the agency at the proposed site, and meet the manual requirements described later in this regulation, including the:

(i) Administrative manual;

(ii) Personnel manual; and

(iii) Clinical manual.

(o) Sample patient records for each treatment service applied for; and

(p) Evidence of sufficient qualified staff to deliver services.

(3) In addition to the requirements in this section, a faith-based organization may implement the requirements of the federal Public Health Act, Sections 581-584 and Section 1955 of 24 U.S.C. 290 and 42 U.S.C. 300x-65.

(4) The agency owner or legal representative must:

(a) Sign the completed application form and submit the original to the department;

(b) Send a copy of the completed application form to the county coordinator in the county where services will be provided;

(c) Submit the application fee with the application materials; and

(d) Report any changes occurring during the certification process.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-015, filed 9/23/03, effective

10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-015, filed 11/21/00, effective 1/1/01.]

WAC 388-805-020 How do I apply for certification of a branch agency or added service? (1) A certified chemical dependency service provider applying for a branch site or an additional certified service must request an abbreviated application packet from the department.

(2) The applicant must submit an abbreviated application, including:

(a) The name of the individual administrator providing management or supervision of the services;

(b) A written declaration that a current copy of the agency policy and procedure manual will be maintained at the branch site and that the manual has been revised to accommodate the differences in business and clinical practices at that site;

(c) An organization chart, showing the relationship of the branch to the main organization, job titles, and lines of authority;

(d) Evidence of sufficient qualified staff to deliver services at the branch site; and

(e) Evidence of meeting the requirements of:

(i) WAC 388-805-015 (1)(b);

(ii) WAC 388-805-015 (2)(h) through (2)(l) and (m); and

(iii) WAC 388-805-015(3).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-020, filed 11/21/00, effective 1/1/01.]

WAC 388-805-030 What are the requirements for opiate substitution treatment program certification? Certification as an opiate substitution treatment program is contingent on the concurrent approval by applicable state regulatory authorities; certification as an opioid treatment program by the Federal CSAT SAMHSA; accreditation by an opioid treatment program accreditation body approved by the Federal CSAT SAMHSA; and licensure by the Federal Drug Enforcement Administration. In addition to WAC 388-805-015 or 388-805-020 requirements, a potential opiate substitution treatment program provider must submit to the department:

(1) Documentation the provider has communicated with the county legislative authority and if applicable, the city legislative authority or tribal legislative authority, in order to secure a location for the new opiate substitution treatment program that meets county, tribal or city land use ordinances.

(2) A completed community relations plan developed in consultation with the county, city or tribal legislative authority or their designee to minimize the impact of the opiate substitution treatment programs upon the business and residential neighborhoods in which the program is located. The plan must include documentation of strategies used to:

(a) Obtain stakeholder input regarding the proposed location;

(b) Address any concerns identified by stakeholders; and

(c) Develop an ongoing community relations plan to address new concerns expressed by stakeholders as they arise.

(3) A copy of the application for a registration certificate from the Washington state board of pharmacy.

(4) A copy of the application for licensure to the Federal Drug Enforcement Administration.

(5) A copy of the application for certification to the Federal CSAT SAMHSA.

(6) A copy of the application for accreditation by an accreditation body approved as an opioid treatment program accreditation body by the Federal CSAT SAMHSA.

(7) Policies and procedures identified under WAC 388-805-700 through 388-805-750.

(8) Documentation that transportation systems will provide reasonable opportunities to persons in need of treatment to access the services of the program.

(9) At least three letters of support from the administrator or their designee of other health care providers within the existing health care system in the area the applicant proposes to establish a new opiate substitution treatment program. The letters must demonstrate a relationship to the service area's existing health care system.

(10) A declaration to limit the number of individual program participants to three hundred fifty as specified in RCW 70.96A.410 (1)(e).

(11) For new applicants, who operate opiate substitution treatment programs in another state, copies of national and state certification/accreditation documentation, and copies of all survey reports written by national and/or state certification or accreditation organizations for each site they have operated an opiate substitution program in over the past six years.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-030, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-030, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-030, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-030, filed 11/21/00, effective 1/1/01.]

WAC 388-805-035 What are the responsibilities for the department when an applicant applies for approval of an opiate substitution treatment program? For purposes of this section, "area" means the county in which an opiate substitution treatment program applicant proposes to locate a certified program, and counties adjacent or near to the county in which the program is proposed to be located. When making a decision on an application for certification of a program, the department must:

(1) Consult with the county legislative authority in the area in which an applicant proposes to locate a program and the city legislative authority or tribal legislative authority applicable to the site in which an applicant proposes to locate a program. The department will request the county and city or tribal legislative authority to notify the department of any applicable requirements or other issues that the department should consider in order to fulfill the requirements of WAC 388-805-030(7), or 388-805-040 (1) through (5);

(2) Not discriminate in its certification decision on the basis of the corporate structure of the applicant;

(3) Consider the size of the population in need of treatment in the area in which the program would be located and certify only applicants whose programs meet the necessary treatment needs of the population;

(4) Determine there is a need in the community for opiate substitution treatment and not certify more programs than justified by the need in that community as described in WAC 388-805-040;

(5) Consider whether the applicant has the capability, or has in the past demonstrated the capability to provide appropriate treatment services to assist persons in meeting legislative goals of abstinence from opiates and opiate substitutes, obtaining mental health treatment, improving economic independence, and reducing adverse consequences associated with illegal use of controlled substances;

(6) Hold at least one public hearing in the county in which the facility is proposed to be located and one public hearing in the area in which the facility is proposed to be located. After consultation with the county legislative authority, the department may have the public hearing in the adjacent county with the largest population, the adjacent county with the largest underserved population, or the county nearest to the proposed location. The hearing must be held at a time and location most likely to permit the largest number of interested persons to attend and present testimony. The department must notify appropriate media outlets of the time, date, and location of the hearing at least three weeks in advance of the hearing.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-035, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-035, filed 9/23/03, effective 10/25/03.]

WAC 388-805-040 How does the department determine there is a need in the community for opiate substitution treatment? The department will determine whether or not there is a demonstrated need in the community for opiate substitution treatment from information provided to the department by the applicant and through department consultation with the city or tribal and county legislative authority, and other appropriate community resources. A "determination of need" for a proposed program will include a review and evaluation of the following criteria:

(1) For the number of potential patients in an area, the department will consider the size of the population in need of treatment in the area in which the program would be located using adult population statistics from the most recent area population trend reports. The department will use the established ratio of .7 percent of the adult population as an estimate for the number of potential patients with an opiate diagnosis in need of treatment services.

(2) For the number of anticipated program slots in an area, the department will multiply the sum of the established ratio of .7 percent of the adult population in subsection (1) of this section by thirty-five percent to determine an estimate of the anticipated need for the number of opiate substitution treatment program slots in the area in which the program would be located.

(3) Demographic and trend data from the area in which the program would be located including the most recent department county trend data, TARGET admission data for opiate substitution treatment from the county, hospital and emergency department admission data from the county, needle exchange data from the county, and other relevant reports and data from county health organizations demonstrating the need for opiate substitution treatment program services.

(4) Availability of other opiate substitution treatment programs near the area of the applicant's proposed program. The department will determine the number of patients, capacity, and accessibility of existing opiate substitution treatment programs near the area of the applicant's proposed program and whether existing programs have the capacity to assume additional patients for treatment services.

(5) Whether the population served or to be served has need for the proposed program and whether other existing services and facilities of the type proposed are available or accessible to meet that need. The assessment will include, but not limited to, consideration of the following:

(a) The extent to which the proposed program meets the need of the population presently served;

(b) The extent to which the underserved need will be met adequately by the proposed program; and

(c) The impact of the service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups to obtain needed health care.

(6) The department will review agency policies and procedures that describe the cost of services to patients, sliding fee scales, and charity care policies, procedures, and goals.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-040, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-040, filed 9/23/03, effective 10/25/03.]

WAC 388-805-060 How does the department conduct an examination of nonresidential facilities? The department must conduct an on-site examination of each new nonresidential applicant's facility or branch facility. The department must determine if the applicant's facility is:

(1) Substantially as described.

(2) Suitable for the purposes intended.

(3) Not a personal residence.

(4) Approved as meeting all building and safety requirements.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-060, filed 11/21/00, effective 1/1/01.]

WAC 388-805-065 How does the department determine disqualification or denial of an application? The department must consider the ability of each person named in the application to operate in accord with this chapter before the department grants or renews certification of a chemical dependency service.

(1) The department must deny an applicant's certification when any of the following conditions occurred and was not satisfactorily resolved, or when any owner or administrator:

(a) Had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended;

(b) Was convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse;

(c) Obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation;

(d) Committed, permitted, aided, or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180;

(e) Demonstrated cruelty, abuse, negligence, misconduct, or indifference to the welfare of a patient or displayed acts of discrimination;

(f) Misappropriated patient property or resources;

(g) Failed to meet financial obligations or contracted service commitments that affect patient care;

(h) Has a history of noncompliance with state or federal regulations in an agency with which the applicant has been affiliated;

(i) Knowingly, or with reason to know, made a false statement of fact or failed to submit necessary information in:

(i) The application or materials attached; and

(ii) Any matter under department investigation.

(j) Refused to allow the department access to records, files, books, or portions of the premises relating to operation of the chemical dependency service;

(k) Willfully interfered with the preservation of material information or attempted to impede the work of an authorized department representative;

(l) Is in violation of any provision of chapter 70.96A RCW; or

(m) Does not meet criminal background check requirements.

(2) The department may deny certification when an applicant:

(a) Fails to provide satisfactory application materials; or

(b) Advertises itself as certified when certification has not been granted, or has been revoked or canceled.

(3) The department may deny an application for certification of an opiate substitution treatment program when:

(a) There is not a demonstrated need in the community for opiate substitution treatment and/or there is not a demonstrated need for more program slots justified by the need in that community;

(b) There is sufficient availability, accessibility, and capacity of other certified programs near the area in which the applicant proposes to locate the program;

(c) The applicant has not demonstrated in the past, the capability to provide the appropriate services to assist the persons who will utilize the program in meeting goals established by the legislature, including:

(i) Abstinence from opiates and opiate substitutes,

(ii) Obtaining mental health treatment,

(iii) Improving economic independence, and

(iv) Reducing adverse consequences associated with illegal use of controlled substances.

(4) The applicant may appeal department decisions in accord with chapter 34.05 RCW, the Washington Administrative Procedure Act and chapter 388-02 WAC.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-065, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-065, filed 11/21/00, effective 1/1/01.]

WAC 388-805-070 What happens after I make application for certification? (1) The department may grant an applicant initial certification after a review of application materials and an on-site visit confirms the applicant has the capacity to operate in compliance with this chapter.

(2) A provider's failure to meet and maintain conditions of the initial certification may result in suspension of certification.

(3) An initial certificate of approval may be issued for up to one year.

(4) The provider must post the certificate in a conspicuous place on the premises.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-070, filed 11/21/00, effective 1/1/01.]

WAC 388-805-075 How do I apply for an exemption? (1) The department may grant an exemption from compliance with specific requirements in this WAC chapter if the exemption does not violate:

(a) An existing federal or state law; or

(b) An existing tribal law.

(2) Providers must submit a signed letter requesting the exemption to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, WA 98504-5330. The provider must assure the exemption request does not:

(a) Jeopardize the safety, health, or treatment of patients; and

(b) Impede fair competition of another service provider.

(3) The department must approve or deny all exemption requests in writing.

(4) The department and the provider must maintain a copy of the decision.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-075, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-075, filed 11/21/00, effective 1/1/01.]

SECTION III—CERTIFICATION FEES

WAC 388-805-080 What are the fee requirements for certification? (1) The department must set fees to be charged for certification.

(2) Providers must pay certification fees:

(a) At the time of application. One-half of the application fee may be refunded if an application is withdrawn before certification or denial; and

(b) Within thirty days of receiving an invoice.

(3) Payment must be made by check, draft, or money order made payable to the department of social and health services.

(4) Fees will not be refunded when certification is denied, revoked, or suspended.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-080, filed 11/21/00, effective 1/1/01.]

WAC 388-805-085 What are the fees for agency certification? (1) Application fees:

(a) New agency	$500
(b) Branch agency	$500
(c) Application for adding one or more services	$200
(d) Change in ownership	$500

(2) Initial and annual certification fees:

(a) For detoxification and residential services:	$26 per licensed bed
(b) For nonresidential services:	
(i) Large size agencies: 3,000 or more patients served per year	$1,125 per year
(ii) Medium size agencies: 1,000-2,999 patients served per year	$750 per year
(iii) Small size agencies: 0-999 patients served per year	$375 per year
(c) For agencies certified through deeming per WAC 388-805-115	$200 per year

(3) Each year providers must complete a declaration form provided by the department indicating the number of patients served annually, the provider's national accreditation status, and other information necessary for establishing fees and updating certification information.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-085, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-085, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-085, filed 11/21/00, effective 1/1/01.]

WAC 388-805-090 May certification fees be waived? (1) Certification fees may be waived when:

(a) The fees would not be in the interest of public health and safety; or

(b) The fees would be to the financial disadvantage of the state; or

(c) The department determines that the cost of processing the application is so small that it warrants granting an application fee waiver.

(2) Providers may submit a letter requesting a waiver of fees to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington, 98504-5330.

(3) Fee waivers may be granted to qualified providers who receive funding from tribal, federal, state or county government resources as follows:

(a) For residential providers: The twenty-six dollar per bed annual fee will be assessed only for those beds not funded by a governmental source;

(b) For nonresidential providers: The amount of the fee waiver must be determined by the percent of the provider's revenues that come from governmental sources, according to the following schedule:

Percent Government Revenues	90-100%	75-89%	50-74%	0-49%
Small agency	No fee	$90	$185	$375
Medium agency	No fee	$185	$375	$750
Large agency	No fee	$285	$565	$1,125

(4) Requests for fee waiver must be mailed to the department and include the following:

(a) The reason for the request;

(b) For residential providers:

(i) Documentation of the number of beds currently licensed by the department of health;

(ii) Documentation showing the number of beds funded by a government entity including, tribal, federal, state or county government sources.

(c) For nonresidential providers:

(i) Documentation of the number of patients served during the previous twelve-month period;

(ii) Documentation showing the amount of government revenues received during the previous twelve-month period;

(iii) Documentation showing the amount of private revenues received during the previous twelve-month period.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-090, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-090, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-090, filed 11/21/00, effective 1/1/01.]

WAC 388-805-095 How long are certificates effective? Certificates are effective for one year from the date of issuance unless:

(1) The department has taken action for noncompliance under WAC 388-805-065, 388-805-125, or 388-805-130; or

(2) The provider does not pay required fees.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-095, filed 11/21/00, effective 1/1/01.]

SECTION IV—MAINTAINING CERTIFICATION

WAC 388-805-100 What do I need to do to maintain agency certification? A service provider's continued certification and renewal is contingent upon:

(1) Completion of an annual declaration of certification.

(2) Payment of certification fees, if applicable.

(3) Providing the essential requirements for chemical dependency treatment, including the following elements:

(a) Treatment process:

(i) Assessments, as described in WAC 388-805-310;

(ii) Treatment planning, as described in WAC 388-805-315 (2)(a) and 388-805-325(11);

(iii) Documenting patient progress, as described in WAC 388-805-315 (1)(b) and 388-805-325(13);

(iv) Treatment plan reviews and updates, as described in WAC 388-805-315 (2)(a), 388-805-325(11) and 388-805-325 (13)(c);

(v) Patient compliance reports, as described in WAC 388-805-315 (4)(b), 388-805-325(17), and 388-805-330;

(vi) Continuing care, transfer summary and discharge planning, as described in WAC 388-805-315 (2)(c) and (d), (6)(a) and (b), and (7)(a), and 388-805-325 (18) and (19); and

(vii) Conducting individual and group counseling, as described in WAC 388-805-315 (2)(b) and 388-805-325(13).

(b) Staffing: Provide sufficient qualified personnel for the care of patients as described in WAC 388-805-140(5) and 388-805-145(5);

(c) Facility:

(i) Provide sufficient facilities, equipment, and supplies for the care and safety of patients as described in WAC 388-805-140 (5) and (6);

(ii) If a residential provider, be licensed by the department of health as described by WAC 388-805-015 (1)(b).

(4) Findings during periodic on-site surveys and complaint investigations to determine the provider's compliance with this chapter. During on-site surveys and complaint investigations, provider representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including patient clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with patients and staff members.

(5) The provider must post the notice of a scheduled department on-site survey in a conspicuous place accessible to patients and staff.

(6) The provider must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-100, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-100, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-100, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-100, filed 11/21/00, effective 1/1/01.]

WAC 388-805-105 What do I need to do for a change in ownership? (1) When a certified chemical dependency service provider plans a change in ownership, the current service provider must submit a change in ownership application form sixty or more days before the proposed date of ownership change.

(2) The current provider must include the following information with the application:

(a) Name and address of each new prospective owner of five percent or more of the organizational assets as required by WAC 388-805-015 (2)(a) through (d);

(b) Current and proposed name (if applicable) of the affected;

(c) Date of the proposed transaction;

(d) A copy of the transfer agreement between the outgoing and incoming owner(s);

(e) If a corporation, the names and addresses of the proposed responsible officers or partners;

(f) A statement regarding the disposition and management of patient records, as described under 42 CFR, Part 2 and WAC 388-805-320; and

(g) A copy of the report of findings from a criminal background check of any new owner of five percent or more of the organizational assets and new administrator when applicable.

(3) The department must determine which, if any, WAC 388-805-015 or 388-805-020 requirements apply to the potential new service provider, depending on the extent of ownership and operational changes.

(4) The department may grant certification to the new owner when the new owner:

(a) Successfully completes the application process; and

(b) Ensures continuation of compliance with rules of this chapter and implementation of plans of correction for deficiencies relating to this chapter, when applicable.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-105, filed 11/21/00, effective 1/1/01.]

WAC 388-805-110 What do I do to relocate or remodel a facility? (1) When a certified chemical dependency service provider plans to relocate or change the physical structure of a facility in a manner that affects patient care, the provider must:

(a) Submit a completed agency relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(b) Submit a sample floor plan that includes information identified under WAC 388-805-015 (2)(j) through (l).

(c) Submit a completed facility accessibility self-evaluation form.

(d) Provide for department examination of nonresidential premises before approval, as described under WAC 388-805-060.

(e) Contact the department of health for approval before relocation or remodel if a residential treatment facility.

(2) Opiate substitution treatment provider must complete WAC 388-805-030, 388-805-035, and 388-805-040 requirements for a facility relocation.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-110, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-110, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-110, filed 11/21/00, effective 1/1/01.]

WAC 388-805-115 How does the department deem national accreditation? (1) The department must deem accreditation by a national chemical dependency accreditation body, recognized by the department, if the treatment provider was initially certified by the department and when:

(a) A major portion of the national accreditation body requirements meet or exceed chapter 388-805 WAC requirements;

(b) The national accreditation time intervals meet or exceed state expectations;

(c) The provider notifies the department of scheduled on-site surveys;

(d) The provider promptly sends a copy of survey findings, corrective action plans, and follow-up responses to the department; and

(e) WAC 388-805-001 through 388-805-135 continue to apply at all times.

(2) The department may apply an abbreviated department survey, which includes requirements specific to Washington state at its regular certification intervals.

(3) The department must act upon:

(a) Complaints received; and

(b) Deficiencies cited by the national accreditation body for which there is no evidence of correction.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-115, filed 11/21/00, effective 1/1/01.]

WAC 388-805-120 How does the department assess penalties? (1) When the department determines that a service provider fails to comply with provider entry requirements or ongoing requirements of this chapter, the department may:

(a) Assess fees to cover costs of added certification activities;

(b) Cease referrals of new patients who are recipients of state or federal funds; and

(c) Notify the county alcohol and drug coordinator and local media of ceased referrals, involuntary cancellations, suspensions, revocations, or nonrenewal of certification.

(2) When the department determines a service provider knowingly failed to report, as ordered by the court pursuant to chapter 46.61 RCW, a patient's noncompliance with treatment, the department must assess the provider a fine of two hundred fifty dollars for each incident of nonreporting.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-120, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-120, filed 11/21/00, effective 1/1/01.]

WAC 388-805-125 How does the department cancel certification? The department may cancel a provider's certification if the provider:

(1) Ceases to provide services for which the provider is certified.

(2) Voluntarily cancels certification.

(3) Fails to submit required certification fees.

(4) Changes ownership without prior notification and approval.

(5) Relocates without prior notification and approval.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-125, filed 11/21/00, effective 1/1/01.]

WAC 388-805-130 How does the department suspend or revoke certification? (1) The department must suspend or revoke a provider's certification when a disqualifying situation described under WAC 388-805-065 applies to a current service provider.

(2) The department must revoke a provider's certification when the provider knowingly failed to report, as ordered by the court pursuant to chapter 46.61 RCW, within a continuous twelve-month period, three incidents of patient noncompliance with treatment ordered by the court.

(3) The department may suspend or revoke a provider's certification when any of the following provider deficiencies or circumstances occur:

(a) A provider fails to provide the essential requirements of chemical dependency treatment as described in WAC 388-805-100(3), and one or more of the following conditions occur:

(i) Violation of a rule threatens or results in harm to a patient;

(ii) A reasonably prudent provider should have been aware of a condition resulting in significant violation of a law or rule;

(iii) A provider failed to investigate or take corrective or preventive action to deal with a suspected or identified patient care problem;

(iv) Noncompliance occurs repeatedly in the same or similar areas;

(v) There is an inability to attain compliance with laws or rules within a reasonable period of time.

(b) The provider fails to submit an acceptable and timely plan of correction for cited deficiencies; or

(c) The provider fails to correct cited deficiencies.

(4) The department may suspend certification upon receipt of a providers written request. Providers requesting voluntary suspension must submit a written request for reinstatement of certification within one year from the effective date of the suspension. The department will review the request for reinstatement, determine if the provider is able to operate in compliance with certification requirements, and notify the provider of the results of the review for reinstatement.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-130, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-130, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-130, filed 11/21/00, effective 1/1/01.]

WAC 388-805-135 What is the prehearing, hearing and appeals process? (1) In case of involuntary certification cancellation, suspension, or revocation of the certification, or a penalty for noncompliance, the department must:

(a) Notify the service provider and the county coordinator of any action to be taken; and

(b) Inform the provider of prehearing and dispute conferences, hearing, and appeal rights under chapter 388-02 WAC.

(2) The department may order a summary suspension of the provider's certification pending completion of the appeal process when the preservation of public health, safety, or welfare requires emergency action.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-135, filed 11/21/00, effective 1/1/01.]

SECTION V—ORGANIZATIONAL STANDARDS

WAC 388-805-140 What are the requirements for a provider's governing body? The provider's governing body, legally responsible for the conduct and quality of services provided, must:

(1) Appoint an administrator responsible for the day-to-day operation of the program.

(2) Maintain a current job description for the administrator including the administrator's authority and duties.

(3) Establish the philosophy and overall objectives for the treatment services.

(4) Notify the department within thirty days, of changes of the agency administrator.

(5) Provide personnel, facilities, equipment, and supplies necessary for the safety and care of patients.

(6) If a nonresidential provider, ensure:

(a) Safety of patients and staff; and

(b) Maintenance and operation of the facility.

(7) Review and approve written administrative, personnel, and clinical policies and procedures required under WAC 388-805-150, 388-805-200, and 388-805-300.

(8) Ensure the administration and operation of the agency is in compliance with:

(a) Chapter 388-805 WAC requirements;

(b) Applicable federal, state, tribal, and local laws and rules; and

(c) Applicable federal, state, tribal, and local licenses, permits, and approvals.

(9) The governing body of a certified opiate substitution treatment program must ensure that treatment is provided to patients in compliance with 42 Code of Federal Regulations, Part 8.12.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-140, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-140, filed 11/21/00, effective 1/1/01.]

WAC 388-805-145 What are the key responsibilities required of an agency administrator? (1) The administrator is responsible for the day-to-day operation of the certified treatment service, including:

(a) All administrative matters;

(b) Patient care services; and

(c) Meeting all applicable rules and ethical standards.

(2) When the administrator is not on duty or on call, a staff person must be delegated the authority and responsibility to act in the administrator's behalf.

(3) The administrator must ensure administrative, personnel, and clinical policy and procedure manuals:

(a) Are developed and adhered to; and

(b) Are reviewed and revised as necessary, and at least annually.

(4) The administrator must employ sufficient qualified personnel to provide adequate chemical dependency treatment, facility security, patient safety and other special needs of patients.

(5) The administrator must ensure all persons providing counseling services are registered, certified or licensed by the department of health.

(6) The administrator must ensure full-time chemical dependency professionals (CDPs), CDP trainees, or other licensed or registered counselors in training to become a CDP do not exceed one hundred twenty hours of patient contact per month.

(7) The administrator must assign the responsibilities for a clinical supervisor to at least one person within the organization.

(8) The administrator of a certified opiate substitution treatment program must ensure that:

(a) The number of patients will not exceed three hundred and fifty unless authorized by the county in which the program is located;

(b) Treatment is provided to patients in compliance with 42 Code of Federal Regulations, Part 8.12; and

(c) A formally designated medical director is appointed who shall assume responsibility for:

(i) All medical services performed; and

(ii) Ensuring the program is in compliance with all applicable Federal, State and local laws and regulations.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-145, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-145, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-145, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-145, filed 11/21/00, effective 1/1/01.]

WAC 388-805-150 What must be included in an agency administrative manual? Each service provider must have and adhere to an administrative manual that contains at a minimum:

(1) The organization's:

(a) Articles and certificate of incorporation if the owner is a corporation;

(b) Partnership agreement if the owner is a partnership; or

(c) Statement of sole proprietorship.

(2) The agency's bylaws if the owner is a corporation.

(3) Copies of a current master license and state business licenses or a current declaration statement that they are updated as required.

(4) The provider's philosophy on and objectives of chemical dependency treatment with a goal of total abstinence, consistent with RCW 70.96A.011.

(5) A policy and procedures describing how services will be made sensitive to the needs of each patient, including assurance that:

(a) Certified interpreters or other acceptable alternatives are available for persons with limited English-speaking proficiency and persons having a sensory impairment; and

(b) Assistance will be provided to persons with disabilities in case of an emergency.

(6) A policy addressing special needs and protection for youth and young adults, and for determining whether a youth or young adult can fully participate in treatment, before admission of:

(a) A youth to a treatment service caring for adults; or

(b) A young adult to a treatment service caring for youth.

(7) An organization chart specifying:

(a) The governing body;

(b) Each staff position by job title, including volunteers, students, and persons on contract; and

(c) The number of full- or part-time persons for each position.

(8) A delegation of authority policy.

(9) A copy of current fee schedules.

(10) A policy and procedures implementing state and federal regulations on patient confidentiality, including provision of a summary of 42 CFR Part 2.22 (a)(1) and (2) to each patient.

(11) A policy and procedures for reporting suspected child abuse and neglect.

(12) A policy and procedures for reporting the death of a patient to the division of alcohol and substance abuse within one business day when:

(a) The patient is in residence;

(b) An outpatient dies on the premises; or

(c) The patient is enrolled in an opiate substitution treatment program.

(13) Patient grievance policy and procedures.

(14) A policy and procedures on reporting of critical incidents and actions taken to the division of alcohol and substance abuse within two business days when an unexpected event occurs.

(15) A smoking policy consistent with the Washington Clean Indoor Air Act, chapter 70.160 RCW.

(16) For a residential provider, a facility security policy and procedures, including:

(a) Preventing entry of unauthorized visitors; and

(b) Use of passes for leaves of patients.

(17) For a nonresidential provider, an evacuation plan for use in the event of a disaster, addressing:

(a) Communication methods for patients, staff, and visitors including persons with a visual or hearing impairment or limitation;

(b) Evacuation of mobility-impaired persons;

(c) Evacuation of children if child care is offered;

(d) Different types of disasters;

(e) Placement of posters showing routes of exit; and

(f) The need to mention evacuation routes at public meetings.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-150, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-150, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-150, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-150, filed 11/21/00, effective 1/1/01.]

WAC 388-805-155 What are the requirements for provider facilities? (1) The administrator must ensure the treatment service site:

(a) Is accessible to a person with a disability;

(b) Has a reception area separate from living and therapy areas;

(c) Has adequate private space for personal consultation with a patient, staff charting, and therapeutic and social activities, as appropriate;

(d) Has secure storage of active and closed confidential patient records; and

(e) Has one private room available if youth are admitted to a detox or residential facility.

(2) The administrator of a nonresidential facility must ensure:

(a) Evidence of a current fire inspection approval;

(b) Facilities and furnishings are kept clean, in good repair;

(c) Adequate lighting, heating, and ventilation; and

(d) Separate and secure storage of toxic substances, which are used only by staff or supervised persons.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-155, filed 11/21/00, effective 1/1/01.]

SECTION VI—HUMAN RESOURCE MANAGEMENT

WAC 388-805-200 What must be included in an agency personnel manual? The administrator must have and adhere to a personnel manual, which contains policies and procedures describing how the agency:

(1) Meets the personnel requirements of WAC 388-805-210 through 388-805-260.

(2) Conducts criminal background checks on its employees in order to comply with the rules specified in RCW 43.43.830 through 43.43.842.

(3) Provides for a drug free work place which includes:

(a) A philosophy of nontolerance of illegal drug-related activity;

(b) Agency standards of prohibited conduct; and

(c) Actions to be taken in the event a staff member misuses alcohol or other drugs.

(4) If a nonresidential provider, provides for prevention and control of communicable disease, including specific training and procedures on:

(a) Bloodborne pathogens, including HIV/AIDS and Hepatitis B;

(b) Tuberculosis; and

(c) Other communicable diseases.

(5) Provides staff orientation prior to assigning unsupervised duties, including orientation to:

(a) The administrative, personnel and clinical manuals;

(b) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities;

(c) Staff and patient grievance procedures; and

(d) The facility evacuation plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-200, filed 11/21/00, effective 1/1/01.]

WAC 388-805-205 What are agency personnel file requirements? (1) The administrator must ensure that there is a current personnel file for each employee, trainee, student, and volunteer, and for each contract staff person who provides or supervises patient care.

(2) The administrator must designate a person to be responsible for management of personnel files.

(3) Each person's file must contain:

(a) A copy of the results of a tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive;

(b) Documentation of training on bloodborne pathogens, including HIV/AIDS and hepatitis B for all employees, volunteers, students, and treatment consultants on contract;

(i) At the time of staff's initial assignment to tasks where occupational exposure may take place;

(ii) Annually thereafter for bloodborne pathogens;

(c) A signed and dated commitment to maintain patient confidentiality in accordance with state and federal confidentiality requirements; and

(d) A record of an orientation to the agency as described in WAC 388-805-200(5).

(4) In addition, each personnel file for staff members providing patient care must contain:

(a) Verification of qualifications for their assigned position including:

(i) For a chemical dependency professional (CDP): A copy of the person's valid CDP certification issued by the department of health (DOH);

(ii) For approved supervisors: Documentation to substantiate the person meets the qualifications of an approved supervisor as defined in WAC 246-811-010;

(iii) For each person engaged in the treatment of chemical dependency, including counselors, physicians, nurses, and other registered, certified, or licensed health care professionals, evidence they comply with the credentialing requirements of their respective professions;

(b) A copy of a current job description, signed and dated by the employee and supervisor which includes:

(i) Job title;

(ii) Minimum qualifications for the position;

(iii) Summary of duties and responsibilities;

(iv) For contract staff, formal agreements or personnel contracts, which describe the nature and extent of patient care services, may be substituted for job descriptions.

(c) A written performance evaluation for each year of employment:

(i) Conducted by the immediate supervisor of each staff member; and

(ii) Signed and dated by the employee and supervisor.

(5) In addition, for residential programs, the personnel file for staff members providing patient care must contain documentation for at least one person on each shift of training in:

(a) Cardiopulmonary resuscitation (CPR); and

(b) First aid.

(6) Documentation of health department training and approval for any staff administering or reading a TB test.

(7) Employees who have been patients of the agency must have personnel records:

(a) Separate from clinical records; and

(b) Have no indication of current or previous patient status.

(8) For probation assessment officers (PAO): Documentation that the person has met the education and experience requirements described in WAC 388-805-220;

(a) For probation assessment officer trainees:

(i) Documentation that the person meets the qualification requirements described in WAC 388-805-225; and

(ii) Documentation of the PAO trainee's supervised experience as described in WAC 388-805-230 including an individual education and experience plan and documentation of progress toward completing the plan.

(9) For information school instructors:

(a) A copy of a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(b) Documentation of continuing education as specified in WAC 388-805-250.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-205, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-205, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-205, filed 11/21/00, effective 1/1/01.]

WAC 388-805-210 What are the requirements for approved supervisors of persons who are in training to become a chemical dependency professional? (1) When an administrator decides to provide training opportunities for persons seeking to become a chemical dependency professional (CDP), the administrator must assign an approved supervisor, as defined in WAC 388-805-005, to each chemical dependency professional trainee (CDPT), or other licensed or registered counselor.

(2) Approved supervisors must provide the CDPT or other licensed or registered counselor assigned to them with documentation substantiating their qualifications as an approved supervisor before the initiation of training.

(3) Approved supervisors must decrease the hours of patient contact allowed under WAC 388-805-145(6) by twenty percent for each full-time CDPT or other licensed or registered counselor supervised.

(4) Approved supervisors are responsible for all patients assigned to the CDPT or other licensed or registered counselor under their supervision.

(5) An approved supervisor must provide supervision to a CDPT or other licensed or registered counselor as required by WAC 246-811-048.

(6) CDPs must review and coauthenticate all clinical documentation of CDPTs or other licensed or registered counselors.

(7) Approved supervisors must supervise, assess and document the progress the CDP trainees or other licensed or registered counselors under their supervision are making toward meeting the requirements described in WAC 246-811-030 and 246-811-047. This documentation must be provided to CDP trainees or other licensed or registered counselors upon request.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-210, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-210, filed 11/21/00, effective 1/1/01.]

WAC 388-805-220 What are the requirements to be a probation assessment officer? A probation assessment officer (PAO) must:

(1) Be employed as a probation officer at a misdemeanant probation department or unit within a county or municipality;

(2) Be certified as a chemical dependency professional, or

(3) Have obtained a bachelor's or graduate degree in a social or health sciences field and have completed twelve quarter or eight semester credits from an accredited college or university in courses that include the following topics:

(a) Understanding addiction and the disease of chemical dependency;

(b) Pharmacological actions of alcohol and other drugs;

(c) Substance abuse and addiction treatment methods;

(d) Understanding addiction placement, continuing care, and discharge criteria, including ASAM PPC criteria;

(e) Cultural diversity including people with disabilities and it's implication for treatment;

(f) Chemical dependency clinical evaluation (screening and referral to include comorbidity);

(g) HIV/AIDS brief risk intervention for the chemically dependent;

(h) Chemical dependency confidentiality;

(i) Chemical dependency rules and regulations.

(4) In addition, a PAO must complete:

(a) Two thousand hours of supervised experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a baccalaureate degree;

(b) One thousand five hundred hours of experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a masters or higher degree.

(5) PAOs, must complete fifteen clock hours each year or thirty clock hours every two years of continuing education in chemical dependency subject areas which will enhance competency as a PAO beginning on January 1 of the year following the year of initial qualification.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-220, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-220, filed 11/21/00, effective 1/1/01.]

WAC 388-805-225 What are the requirements to be a probation assessment officer trainee? A probation assessment officer (PAO) trainee must:

(1) Be employed as a probation officer at a misdemeanant probation department or unit within a county or municipality; and

(2) Be directly supervised and tutored by a PAO.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-225, filed 11/21/00, effective 1/1/01.]

WAC 388-805-230 What are the requirements for supervising probation assessment officer trainees? (1) Probation assessment officers (PAO) are responsible for all offenders assigned to PAO trainees under their supervision.

(2) PAO trainee supervisors must:

(a) Review and coauthenticate all trainee assessments entered in each offender's assessment record;

(b) Assist the trainee to develop and maintain an individualized education and experience plan (IEEP) designed to assist the trainee in obtaining the education and experience necessary to become a PAO;

(c) Provide the trainee orientation to the various laws and regulations that apply to the delivery of chemical dependency assessment and treatment services;

(d) Instruct the trainee in assessment methods and the transdisciplinary foundations described in the addiction counseling competencies;

(e) Observe the trainee conducting assessments; and

(f) Document quarterly evaluations of the progress of each trainee.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-230, filed 11/21/00, effective 1/1/01.]

WAC 388-805-240 What are the requirements for student practice in treatment agencies? (1) The treatment provider must have a written agreement with each educational institution using the treatment agency as a setting for student practice.

(2) The written agreement must describe the nature and scope of student activity at the treatment setting and the plan for supervision of student activities.

(3) Each student and academic supervisor must sign a confidentiality statement, which the provider must retain.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-240, filed 11/21/00, effective 1/1/01.]

WAC 388-805-250 What are the requirements to be an information school instructor? (1) An information school instructor must have a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department if not a chemical dependency professional (CDP).

(2) To remain qualified, the information school instructor must maintain information school instructor status by completing fifteen clock hours of continuing education if not a CDP:

(a) During each two-year period beginning January of the year following initial qualification; and

(b) In subject areas that increase knowledge and skills in training, teaching techniques, curriculum planning and development, presentation of educational material, laws and rules, and developments in the chemical dependency field.

[Statutory Authority: RCW 70.96A.090. and Chapter 70.96A RCW; chapter 242, Laws of 2001; 42 C.F.R. Part 8. 03-20-020, § 388-805-250, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-250, filed 11/21/00, effective 1/1/01.]

WAC 388-805-260 What are the requirements for using volunteers in a treatment agency? (1) Each volunteer assisting a provider must be oriented as required under WAC 388-805-200(5).

(2) A volunteer must meet the qualifications of the position to which the person is assigned.

(3) A volunteer may provide counseling services when the person meets the requirements for a chemical dependency professional trainee or is a chemical dependency professional.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-260, filed 11/21/00, effective 1/1/01.]

SECTION VII—PROFESSIONAL PRACTICES

WAC 388-805-300 What must be included in the agency clinical manual? Each chemical dependency service provider must have and adhere to a clinical manual containing patient care policies and procedures, including:

(1) How the provider meets WAC 388-805-305 through 388-805-350 requirements.

(2) How the provider will meet applicable certified service standards for the level of program service requirements:

Allowance of up to twenty percent of education time to consist of film or video presentations.

(3) Identification of resources and referral options so staff can make referrals required by law and as indicated by patient needs.

(4) Assurance that there is an identified clinical supervisor who:

(a) Is a chemical dependency professional (CDP);

(b) Has documented competency in clinical supervision;

(c) Reviews and documents a sample of patient records of each CDP semi-annually;

(d) Ensures implementation of assessment, treatment, continuing care, transfer and discharge plans in accord with WAC 388-805-315; and

(e) Ensures continued competency of each CDP in assessment, treatment, continuing care, transfer, and dis-

charge plans in accord with WAC 388-805-310 and 388-805-315.

(5) Patient admission, continued service, and discharge criteria using PPC.

(6) Policies and procedures to implement the following requirements:

(a) The administrator must not admit or retain a person unless the person's treatment needs can be met;

(b) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess and refer each patient to the appropriate treatment service; and

(c) A person needing detoxification must immediately be referred to a detoxification provider, unless the person needs acute care in a hospital.

(7) Additional requirements for opiate substitution treatment programs:

(a) A program physician must ensure that a person is currently addicted to an opioid drug and that the person became addicted at least one year before admission to treatment;

(b) A program physician must ensure that each patient voluntarily chooses maintenance treatment and provides informed written consent to treatment;

(c) A program physician must ensure that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient;

(d) A person under eighteen years of age needing opiate substitution treatment is required to have had two documented attempts at short-term detoxification or drug-free treatment within a twelve-month period. A waiting period of no less than seven days is required between the first and second short-term detoxification treatment;

(e) No person under eighteen years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to treatment;

(f) A program physician may waive the requirement of a one year history of addiction under subsection (7)(a) of this section, for patients released from penal institutions (within six months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to two years after discharge);

(g) Documentation in each patient's record that the service provider made a good faith effort to review if the patient is enrolled in any other opiate substitution treatment service;

(h) When the medical director or program physician of an opiate substitution treatment program provider in which the patient is enrolled determines that exceptional circumstances exist, the patient may be granted permission to seek concurrent treatment at another opiate substitution treatment program provider. The justification for finding exceptional circumstances for double enrollment must be documented in the patient's record at both treatment program providers.

(8) Tuberculosis screening for prevention and control of TB in all detox, residential, and outpatient programs, including:

(a) Obtaining a history of preventive or curative therapy;

(b) Screening and related procedures for coordinating with the local health department; and

(c) Implementing TB control as provided by the department of health TB control program.

(9) HIV/AIDS information, brief risk intervention, and referral.

(10) Limitation of group counseling sessions to twelve or fewer patients.

(11) Counseling sessions with nine to twelve youths to include a second adult staff member.

(12) Provision of education to each patient on:

(a) Alcohol, other drugs, and chemical dependency;

(b) Relapse prevention; and

(c) HIV/AIDS, hepatitis, and TB.

(13) Provision of education or information to each patient on:

(a) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy;

(b) Emotional, physical, and sexual abuse; and

(c) Nicotine addiction.

(14) An outline of each lecture and education session included in the service, sufficient in detail for another trained staff person to deliver the session in the absence of the regular instructor.

(15) Assigning of work to a patient by a CDP when the assignment:

(a) Is part of the treatment program; and

(b) Has therapeutic value.

(16) Use of self-help groups.

(17) Patient rules and responsibilities, including disciplinary sanctions for noncomplying patients.

(18) If youth are admitted, a policy and procedure for assessing the need for referral to child welfare services.

(19) Implementation of the deferred prosecution program.

(20) Reporting status of persons convicted under chapter 46.61 RCW to the department of licensing.

(21) Asking at intake or next counseling session if the patient has been court ordered to chemical dependency or mental health treatment and is under supervision by the department of corrections, and documenting the patient's response in the clinical record.

(22) For patients that are court ordered to receive chemical dependency or mental health treatment and under department of corrections supervision, the provider must request:

(a) Authorizations to share information with the department of corrections, the county designated chemical dependency specialist and any other court ordered treatment provider; or

(b) A copy of the court order that exempts the patient from the reporting requirements with the department of corrections and mental health provider.

(c) If a patient refuses to sign a release, document attempt in the patient record.

(23) Nonresidential providers must have policies and procedures on:

(a) Medical emergencies;

(b) Suicidal and mentally ill patients;

(c) Laboratory tests, including UA's and drug testing;

(d) Services and resources for pregnant women:

(i) A pregnant woman who is not seen by a private physician must be referred to a physician or the local first steps maternity care program for determination of prenatal care needs; and

(ii) Services include discussion of pregnancy specific issues and resources.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-300, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-300, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-300, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-300, filed 11/21/00, effective 1/1/01.]

WAC 388-805-305 What are patients' rights requirements in certified agencies? (1) Each service provider must ensure each patient:

(a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria;

(b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(c) Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect;

(d) Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Has all clinical and personal information treated in accord with state and federal confidentiality regulations;

(f) Has the opportunity to review their own treatment records in the presence of the administrator or designee;

(g) Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral;

(h) Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available;

(i) Is provided reasonable opportunity to practice the religion of their choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. The patient has the right to refuse participation in any religious practice;

(j) Is allowed necessary communication:

(i) Between a minor and a custodial parent or legal guardian;

(ii) With an attorney; and

(iii) In an emergency.

(k) Is protected from abuse by staff at all times, or from other patients who are on agency premises, including:

(i) Sexual abuse or harassment;

(ii) Sexual or financial exploitation;

(iii) Racism or racial harassment; and

(iv) Physical abuse or punishment.

(l) Is fully informed and receives a copy of counselor disclosure requirements established under RCW 18.19.060;

(m) Receives a copy of patient grievance procedures upon request; and

(n) In the event of an agency closure or treatment service cancellation, each patient must be:

(i) Given thirty days notice;

(ii) Assisted with relocation;

(iii) Given refunds to which the person is entitled; and

(iv) Advised how to access records to which the person is entitled.

(2) A faith-based service provider must ensure the right of patients to receive treatment without religious coercion by ensuring that:

(a) Patients must not be discriminated against when seeking services;

(b) Patients must have the right to decide whether or not to take part in inherently religious activities; and

(c) Patients have the right to receive a referral to another service provider if they object to a religious provider.

(3) A service provider must obtain patient consent for each release of information to any other person or entity. This consent for release of information must include:

(a) Name of the consenting patient;

(b) Name or designation of the provider authorized to make the disclosure;

(c) Name of the person or organization to whom the information is to be released;

(d) Nature of the information to be released, as limited as possible;

(e) Purpose of the disclosure, as specific as possible;

(f) Specification of the date or event on which the consent expires;

(g) Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;

(h) Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and

(i) A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.

(4) A service provider must notify patients that outside persons or organizations which provide services to the agency are required by written agreement to protect patient confidentially

(5) A service provider must notify an ADATSA recipient of the recipient's additional rights as required by WAC 388-800-0090.

(6) The administrator must ensure a copy of patients' rights is given to each patient receiving services, both at admission and in case of disciplinary discharge.

(7) The administrator must post a copy of patients' rights in a conspicuous place in the facility accessible to patients and staff.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-305, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-305, filed 11/21/00, effective 1/1/01.]

WAC 388-805-310 What are the requirements for chemical dependency assessments? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document an assessment of each patient's involvement with alcohol and other drugs. The CDP's assessment must include:

(1) A face-to-face diagnostic interview with each patient to obtain, review, evaluate, and document the following:

(a) A history of the patient's involvement with alcohol and other drugs, including:

(i) The type of substances used;

(ii) The route of administration; and

(iii) Amount, frequency, and duration of use.

(b) History of alcohol or other drug treatment or education;

(c) The patient's self-assessment of use of alcohol and other drugs;

(d) A relapse history;

(e) A legal history; and

(f) In addition, for persons who have been charged with a violation under RCW 46.61.502 or 46.61.504 RCW, ensure the assessment includes an evaluation in the written summary of the patient's:

(i) Blood or breath alcohol level and other drug levels or documentation of the patient's refusal at the time of the arrest, if available;

(ii) Self reported driving record and the abstract of the patient's legal driving record; and

(iii) If the initial finding is other than substance dependence, the assessment must also include:

(A) The police report or documentation of efforts to include this information;

(B) A court originated criminal case history or documentation of efforts to include this information; and

(C) The results of a urinalysis or drug testing obtained at the time of the assessment or documentation of efforts to include this information.

(2) If the patient is in need of treatment, a CDP or CDP trainee under supervision of a CDP must evaluate the assessment using PPC dimensions for the patient placement decision.

(3) If an assessment is conducted on a youth, and the patient is in need of treatment, the CDP, or CDP trainee under supervision of a CDP, must also obtain the following information:

(a) Parental and sibling use of alcohol and other drugs;

(b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;

(c) Past and present parent/guardian custodial status, including running away and out-of-home placements;

(d) History of emotional or psychological problems;

(e) History of child or adolescent developmental problems; and

(f) Ability of parents/guardians to participate in treatment.

(4) Documentation of the information collected, including:

(a) A diagnostic assessment statement including sufficient data to determine a patient diagnosis supported by criteria of substance abuse or substance dependence;

(b) A written summary of the data gathered in subsections (1), (2), and (3) of this section that supports the treatment recommendation;

(c) A statement regarding provision of an HIV/AIDS brief risk intervention, and referrals made; and

(d) Evidence the patient:

(i) Was notified of the assessment results; and

(ii) Documentation of treatment options provided, and the patient's choice; or

(iii) If the patient was not notified of the results and advised of referral options, the reason must be documented.

(5) Completion and submission of all reports required by the courts, department of corrections, department of licensing, and department of social and health services in a timely manner.

(6) Referral of an adult or minor who requires assessment for involuntary chemical dependency treatment to the county-designated chemical dependency specialist.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-310, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-310, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-310, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-310, filed 11/21/00, effective 1/1/01.]

WAC 388-805-315 What are the requirements for treatment, continuing care, transfer, and discharge plans? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must be responsible for the overall treatment plan for each patient, including:

(a) Patient involvement in treatment planning;

(b) Documentation of progress toward patient attainment of goals; and

(c) Completeness of patient records.

(2) A CDP or a CDP trainee under supervision of a CDP must:

(a) Develop the individualized treatment plan based upon the assessment and update the treatment plan based upon achievement of goals, or when new problems are identified;

(b) Conduct individual and group counseling;

(c) Develop the continuing care plan; and

(d) Complete the discharge summary.

(3) A CDP, or CDP trainee under supervision of a CDP, must also include in the treatment plan for youth problems identified in specific youth assessment, including any referrals to school and community support services.

(4) A CDP, or CDP trainee under supervision of a CDP, must follow up when a patient misses an appointment to:

(a) Try to motivate the patient to stay in treatment; and

(b) Report a noncompliant patient to the committing authority as appropriate.

(5) A CDP, or CDP trainee under supervision of a CDP, must involve each patient's family or other support persons, when the patient gives written consent:

(a) In the treatment program; and

(b) In self-help groups.

(6) When transferring a patient from one certified treatment service to another within the same agency, at the same location, a CDP, or a CDP trainee under supervision of a CDP, must:

(a) Update the patient assessment and treatment plan; and

(b) Provide a summary report of the patient's treatment and progress, in the patient's record.

(7) A CDP, or CDP trainee under supervision of a CDP, must meet with each patient at the time of discharge from any treatment agency, unless in detox or when a patient leaves treatment without notice, to:

(a) Finalize a continuing care plan to assist in determining appropriate recommendation for care;

(b) Assist the patient in making contact with necessary agencies or services; and

(c) Provide the patient a copy of the plan.

(8) When transferring a patient to another treatment provider, the current provider must forward copies of the following information to the receiving provider when a release of confidential information is signed by the patient:

(a) Patient demographic information;

(b) Diagnostic assessment statement and other assessment information, including:

(i) Documentation of the HIV/AIDS intervention;

(ii) TB test result;

(iii) A record of the patient's detox and treatment history;

(iv) The reason for the transfer; and

(v) Court mandated, department of correction supervision status or agency recommended follow-up treatment.

(c) Discharge summary; and

(d) The plan for continuing care or treatment.

(9) A CDP, or CDP trainee under supervision of a CDP, must complete a discharge summary, within seven days of each patient's discharge from the agency, which includes:

(a) The date of discharge; and

(b) A summary of the patient's progress toward each treatment goal, except in detox.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-315, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-315, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-315, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-315, filed 11/21/00, effective 1/1/01.]

WAC 388-805-320 What are the requirements for a patient record system? Each service provider must have a comprehensive patient record system maintained in accord with recognized principles of health record management. The provider must ensure:

(1) A designated individual is responsible for the record system;

(2) A secure storage system which:

(a) Promotes confidentiality of and limits access to both active and inactive records; and

(b) Protects active and inactive files from damage during storage.

(3) Patient record policies and procedures on:

(a) Who has access to records;

(b) Content of active and inactive patient records;

(c) A systematic method of identifying and filing individual patient records so each can be readily retrieved;

(d) Assurance that each patient record is complete and authenticated by the person providing the observation, evaluation, or service;

(e) Retention of patient records for a minimum of six years after the discharge or transfer of the patient; and

(f) Destruction of patient records.

(4) In addition to subsection (1) through (3) of this section, an opiate substitution treatment program provider must ensure that the patient record system comply with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.

(5) In addition to subsection (1) through (3) of this section, providers maintaining electronic patient records must:

(a) Make records available in paper form upon request:

(i) For review by the department;

(ii) By patients requesting record review as authorized by WAC 388-805-305 (1)(f).

(b) Provide secure, limited access through means that prevent modification or deletion after initial preparation;

(c) Provide for back up of records in the event of equipment, media or human error;

(d) Provide for protection from unauthorized access, including network and internet access.

(6) In case of an agency closure, the provider closing its treatment agency must arrange for the continued management of all patient records. The closing provider must notify the department in writing of the mailing and street address where records will be stored and specify the person managing the records. The closing provider may:

(a) Continue to manage the records and give assurance they will respond to authorized requests for copies of patient records within a reasonable period of time;

(b) Transfer records of patients who have given written consent to another certified provider;

(c) Enter into a qualified service organization agreement with a certified provider to store and manage records, when the outgoing provider will no longer be a chemical dependency treatment provider; or

(d) In the event none of the arrangements listed in (a) through (c) of this subsection can be made, the closing provider must arrange for transfer of patient records to the department.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-320, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-320, filed 11/21/00, effective 1/1/01.]

WAC 388-805-325 What are the requirements for patient record content? The service provider must ensure patient record content includes:

(1) Demographic information;

(2) A chemical dependency assessment and history of involvement with alcohol and other drugs;

(3) Documentation of the patient's response when asked if the patient is under:

(a) Department of corrections supervision; and

(b) Civil or criminal court ordered mental health or chemical dependency treatment; or

(c) A copy of the court order exempting patient from reporting requirements.

(4) Documentation the patient was informed of the diagnostic assessment and options for referral or the reason not informed;

(5) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2 and 45 CFR, Part 160 through 164;

(6) Documentation the patient was informed of treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;

(7) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody, involuntary treatment, or the department of corrections;

(8) Documentation the patient received counselor disclosure information, acknowledged by the provider and patient by signature and date;

(9) Documentation of the patient's tuberculosis test and results;

(10) Documentation the patient received the HIV/AIDS brief risk intervention;

(11) Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews, addressing:

(a) Patient biopsychosocial problems;

(b) Treatment goals;

(c) Estimated dates or conditions for completion of each treatment goal;

(d) Approaches to resolve the problems;

(e) Identification of persons responsible for implementing the approaches;

(f) Medical orders, if appropriate.

(12) Documentation of referrals made for specialized care or services;

(13) At least weekly individualized documentation of ongoing services in residential services, and as required in intensive outpatient and outpatient services, including:

(a) Date, duration, and content of counseling and other treatment sessions;

(b) Ongoing assessments of each patient's participation in and response to treatment and other activities;

(c) Progress notes as events occur, and treatment plan reviews as specified under each treatment service of chapter 388-805 WAC; and

(d) Documentation of missed appointments.

(14) Medication records, if applicable;

(15) Laboratory reports, if applicable;

(16) Properly completed authorizations for release of information;

(17) Copies of all correspondence related to the patient, including any court orders and reports of noncompliance;

(18) A copy of the continuing care plan signed and dated by the CDP and the patient; and

(19) The discharge summary.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-325, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-325, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-325, filed 11/21/00, effective 1/1/01.]

WAC 388-805-330 What are the requirements for reporting patient noncompliance? The following standards define patient noncompliance behaviors and set minimum time lines for reporting these behaviors to the appropriate court, community corrections officer, or county designated chemical dependency specialist.

(1) Reporting patient noncompliance is contingent upon obtaining a properly completed authorization to release confidential information form meeting the requirements of 42 CFR Part 2 and 45 CFR Parts 160 and 164 or through a court order authorizing the disclosure pursuant to 42 CFR Part 2, Section 2.63 through 2.67.

(2) Chemical dependency service providers failing to report patient noncompliance with court ordered or deferred prosecution treatment requirements may be considered in violation of chapter 46.61 RCW, RCW 70.96A.142 or chapter 10.05 RCW reporting requirements and be subject to penalties specified in WAC 388-805-120, 388-805-125, and 388-805-130.

(3) For patients under the department of corrections supervision and court ordered to treatment, the provider must notify the designated chemical dependency specialist within three working days from obtaining information of any violation of the terms of the court order for purposes of revocation of the patient's conditional release.

(4) For emergent noncompliance: The following noncompliance is considered emergent noncompliance and must be reported to the appropriate court within three working days from obtaining the information:

(a) Patient failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by patient self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test;

(b) Patient reports a subsequent alcohol/drug related arrest;

(c) Patient leaves program against program advice or is discharged for rule violation.

(5) For nonemergent noncompliance: The following noncompliance is considered nonemergent noncompliance and must be reported to the appropriate court as required by subsection (6) and (7) of this section:

(a) Patient has unexcused absences or failure to report. Agencies must report all patient unexcused absences, including failure to attend self-help groups. Report failure of patient to provide agency with documentation of attendance at self-help groups if under a deferred prosecution order or required by the treatment plan. In providing this report, include the agency's recommendation for action.

(b) Patient failure to make acceptable progress in any part of the treatment plan. Report details of the patient's noncompliance behavior along with a recommendation for action.

(6) If a court accepts monthly progress reports, nonemergent noncompliance may be reported in monthly progress reports, which must be mailed to the court within ten working days from the end of each reporting period.

(7) If a court does not wish to receive monthly reports and only requests notification of noncompliance or other significant changes in patient status, the reports should be transmitted as soon as possible, but in no event longer than ten working days from the date of the noncompliance.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-330, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-330, filed 11/21/00, effective 1/1/01.]

SECTION VIII—OUTCOMES EVALUATION

WAC 388-805-350 What are the requirements for outcomes evaluation? Each service provider must develop

and implement policies and procedures for outcomes evaluation, to monitor and evaluate program effectiveness and patient satisfaction for the purpose of program improvement.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-350, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-350, filed 11/21/00, effective 1/1/01.]

SECTION IX—PROGRAM SERVICE STANDARDS

WAC 388-805-400 What are the requirements for detoxification providers? Detoxification services include acute and subacute services. To be certified to offer detoxification services, a provider must:

(1) Meet WAC 388-805-001 through 388-805-320, 388-805-330, and 388-805-350 requirements; and

(2) Meet relevant requirements of chapter 246-337 WAC.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-400, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-400, filed 11/21/00, effective 1/1/01.]

WAC 388-805-410 What are the requirements for detox staffing and services? (1) The service provider must ensure staffing as follows:

(a) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, to assess, counsel, and attempt to motivate each patient for referral;

(b) Other staff as necessary to provide services needed by each patient;

(c) All personnel providing patient care, except licensed staff and CDPs, must complete a minimum of forty hours of documented training before assignment of patient care duties. The personnel training must include:

(i) Chemical dependency;

(ii) HIV/AIDS and hepatitis B education;

(iii) TB prevention and control; and

(iv) Detox screening, admission, and signs of trauma.

(d) All personnel providing patient care must have current training in:

(i) Cardio-pulmonary resuscitation (CPR); and

(ii) First aid.

(2) The service provider must ensure detoxification services include:

(a) A staff member who demonstrates knowledge about addiction, and is skilled in observation and eliciting information, will perform a screening of each person prior to admission;

(b) Counseling of each patient by a CDP, or CDP trainee under supervision of a CDP, at least once:

(i) Regarding the patient's chemical dependency; and

(ii) Attempting to motivate each person to accept referral into a continuum of care for chemical dependency treatment.

(c) Sleeping arrangements that permit observation of patients;

(d) Separate sleeping rooms for youth and adults; and

(e) Referral of each patient to other appropriate treatment services.

(3) The service provider must ensure detoxification patient records include:

(a) Demographic information;

(b) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2;

(c) Documentation the patient was informed of treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;

(d) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody and involuntary treatment;

(e) Documentation the patient receive counselor disclosure information, acknowledged by the provider and patient by signature and date;

(f) Documentation the patient received the HIV/AIDS brief risk intervention;

(g) Progress notes each shift and as events occur;

(h) Medication records, if applicable;

(i) Laboratory reports, if applicable;

(j) Properly completed authorizations for release of information; and

(k) The discharge summary, which includes the patient's physical condition.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-410, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-410, filed 11/21/00, effective 1/1/01.]

WAC 388-805-500 What are the requirements for residential providers? To be certified to offer intensive inpatient, recovery, or long-term residential services, a provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-510 through 388-805-550 as applicable; and

(3) Chapter 246-337 WAC as required for department of health licensing.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-500, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-500, filed 11/21/00, effective 1/1/01.]

WAC 388-805-510 What are the requirements for residential providers admitting youth? A residential service provider admitting youth must ensure:

(1) A youth will be admitted only with the written permission of a parent or legal guardian. In cases where the youth meets the requirements of child in need of services (CHINS) the youth may sign themselves into treatment.

(2) The youth must agree to, and both the youth and parent or legal guardian must sign the following when possible:

(a) Statement of patient rights and responsibilities;

(b) Treatment or behavioral contracts; and

(c) Any consent or release form.

(3) Youth chemical dependency treatment must include:

(a) Group meetings to promote personal growth; and

(b) Recreational, leisure, and other therapy and related activities.

(4) A certified teacher or tutor must provide each youth one or more hours per day, five days each week, of super-

vised academic tutoring or instruction when the youth is unable to attend school for an estimated period of four weeks or more. The provider must:

(a) Document the patient's most recent academic placement and achievement level; and

(b) Obtain schoolwork, where applicable, from the patient's home school or provide schoolwork and assignments consistent with the person's academic level and functioning.

(5) Adult staff must lead or supervise seven or more hours of structured recreation each week.

(6) Staff must conduct room checks frequently and regularly when patients are in their rooms.

(7) A person fifteen years of age or younger must not room with a person eighteen years of age or older.

(8) Sufficient numbers of adult staff, whose primary task is supervision of patients, must be trained and available at all times to ensure appropriate supervision, patient safety, and compliance with WAC 388-805-520.

(9) In coed treatment services, there must be at least one adult staff person of each gender present or on call at all times.

(10) There must be at least one chemical dependency professional (CDP) for every ten youth patients.

(11) Staff must document attempts to notify the parent or legal guardian within two hours of any change in the status of a youth.

(12) For routine discharge, each youth must be discharged to the care of the youth's legal custodian.

(13) For emergency discharge and when the custodian is not available, the provider must contact the appropriate authority.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-510, filed 11/21/00, effective 1/1/01.]

WAC 388-805-520 What are the requirements for youth behavior management? (1) Upon application for a youth's admission, a service provider must:

(a) Advise the youth's parent and other referring persons of the programmatic and physical plant capabilities and constraints in regard to providing treatment with or without a youth's consent;

(b) Obtain the parent's or other referring person's agreement to participate in the treatment process as appropriate and possible; and

(c) Obtain the parent's or other referring person's agreement to return and take custody of the youth as necessary and appropriate on discharge or transfer.

(2) The administrator must ensure policies and procedures are written and implemented which detail least to increasingly restrictive practices used by the provider to stabilize and protect youth who are a danger to self or others, including:

(a) Obtaining signed behavioral contracts from the youth, at admission and updated as necessary;

(b) Acknowledging positive behavior and fostering dignity and self respect;

(c) Supporting self-control and the rights of others;

(d) Increased individual counseling;

(e) Increased staff monitoring;

(f) Verbal deescalation;

(g) Use of unlocked room for voluntary containment or time-out;

(h) Use of therapeutic physical intervention techniques during a time limited immediate crisis to prevent or limit free body movement that may cause harm to the person or others; and

(i) Emergency procedures, including notification of the parent, guardian or other referring person, and, when appropriate, law enforcement.

(3) The provider must ensure staff is trained in safe and therapeutic techniques for dealing with a youth's behavioral and emotional crises, including:

(a) Verbal deescalation;

(b) Crisis intervention;

(c) Anger management;

(d) Suicide assessment and intervention;

(e) Conflict management and problem solving skills;

(f) Management of assaultive behavior;

(g) Proper use of therapeutic physical intervention techniques; and

(h) Emergency procedures.

(4) To reduce the possibility of a youth's unauthorized exit from the residential treatment site, the provider may have:

(a) An unlocked room for voluntary containment or time-out;

(b) A secure perimeter, such as a nonscalable fence with locked gates; and

(c) Locked windows and exterior doors.

(5) Providers using holding mechanisms in subsection (4) of this section must meet current Uniform Building Code requirements, which include fire safety and special egress control devices, such as alarms and automatic releases.

(6) When less restrictive measures are not sufficient to de-escalate a behavioral crisis, clinical staff may use, for voluntary containment or time-out of a youth, a quiet unlocked room which has a window for observation and:

(a) The clinical supervisor or designated alternate must be notified immediately of the staff person's use of a quiet room for a youth, and must determine its appropriateness;

(b) A chemical dependency professional (CDP) or designated clinical alternate must consult with the youth immediately and at least every ten minutes, for counseling, assistance, and to maintain direct communication; and

(c) The clinical supervisor or designated alternate must evaluate the youth and determine the need for mental health consultation.

(7) Youth who demonstrate continuing refusal to participate in treatment or continuing to exhibit behaviors that present health and safety risks to self, other patients, or staff may be discharged or transferred to more appropriate care after:

(a) Interventions appropriate to the situation from those listed in subsection (2) of this section have been attempted without success;

(b) The person has been informed of the consequences and return options;

(c) The parents, guardian, or other referring person has been notified of the emergency and need to transfer or discharge the person; and

(d) Arrangements are made for the physical transfer of the person into the custody of the youth's parent, guardian, or other appropriate person or program.

(8) Involved staff must document the circumstances surrounding each incident requiring intervention in the youth's record and include:

(a) The precipitating circumstances;

(b) Measures taken to resolve the incident;

(c) Final resolution; and

(d) Record of notification of appropriate others.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-520, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-520, filed 11/21/00, effective 1/1/01.]

WAC 388-805-530 What are the requirements for intensive inpatient services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(a) Complete the initial treatment plan within five days of admission;

(b) Conduct at least one face-to-face individual chemical dependency counseling session with each patient each week;

(c) Provide a minimum of ten hours of chemical dependency counseling with each patient each week;

(d) Document a treatment plan review, at least weekly, which updates patient status, progress toward goals; and

(e) Refer each patient for ongoing treatment or support, as necessary, upon completion of treatment.

(2) The provider must ensure a minimum of twenty hours of treatment services for each patient each week; up to ten hours may be education.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-530, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-530, filed 11/21/00, effective 1/1/01.]

WAC 388-805-540 What are the requirements for recovery house services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide a minimum of five hours of treatment, for each patient each week, consisting of:

(a) Education regarding drug-free and sober living; and

(b) Individual or group counseling.

(2) A CDP, or CDP trainee under supervision of a CDP, must document a treatment plan review at least monthly; and

(3) Staff must assist patients with general reentry living skills and, for youth, continuation of educational or vocational training.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-540, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-540, filed 11/21/00, effective 1/1/01.]

WAC 388-805-550 What are the requirements for long-term treatment services? Each chemical dependency service provider must ensure each patient receives:

(1) Education regarding alcohol, other drugs, and other addictions, at least two hours each week.

(2) Individual or group counseling by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP, a minimum of two hours each week.

(3) Education on social and coping skills.

(4) Social and recreational activities.

(5) Assistance in seeking employment, when appropriate.

(6) Document a treatment plan review at least monthly.

(7) Assistance with reentry living skills.

(8) A living arrangement plan.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-550, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-550, filed 11/21/00, effective 1/1/01.]

WAC 388-805-600 What are the requirements for outpatient providers? To be certified to provide intensive or other outpatient services, a chemical dependency service provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-610 through 388-805-630, as applicable; and

(3) WAC 388-805-700 through 388-805-750, if offering opiate substitution treatment program services.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-600, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-600, filed 11/21/00, effective 1/1/01.]

WAC 388-805-610 What are the requirements for intensive outpatient treatment services? (1) Patients admitted to intensive outpatient treatment under a deferred prosecution order pursuant to chapter 10.05 RCW, must complete intensive treatment as described in subsection (2) of this section. Any exceptions to this requirement must be approved, in writing, by the court having jurisdiction in the case.

(2) Each chemical dependency service provider must ensure intensive outpatient services are designed to deliver:

(a) A minimum of seventy-two hours of treatment services within a maximum of twelve weeks,

(b) The first four weeks of treatment must consist of:

(i) At least three sessions each week;

(ii) Each group session must last at least one hour; and

(iii) Each session must be on separate days of the week.

(c) Individual chemical dependency counseling sessions with each patient at least once a month, or more if clinically indicated;

(d) Education totaling not more than fifty percent of patient treatment services regarding alcohol, other drugs, relapse prevention, HIV/AIDS, hepatitis B, hepatitis C, and TB prevention, and other air/bloodborne pathogens;

(e) Self-help group attendance in addition to the seventy-two hours;

(f) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document a review of each patient's treatment plan in individual chemical dependency counseling sessions, if appropriate, to assess adequacy and attainment of goals;

(g) Upon completion of intensive outpatient treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-610, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-610, filed 11/21/00, effective 1/1/01.]

WAC 388-805-620 What are the requirements for outpatient services? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(1) Complete admission assessments, prior to admission unless participation in this outpatient treatment service is part of the same provider's continuum of care.

(2) Complete an initial individualized treatment plan prior to the patient's participation in treatment.

(3) Conduct group or individual chemical dependency counseling sessions for each patient, each month, according to an individual treatment plan.

(4) Conduct and document a treatment plan review for each patient:

(a) Once a month for the first three months; and

(b) Quarterly thereafter or sooner if required by other laws.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-620, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-620, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-620, filed 11/21/00, effective 1/1/01.]

WAC 388-805-625 What are the requirements for outpatient services for persons subject to RCW 46.61.-5056? (1) Patients admitted to outpatient treatment subject to RCW 46.61.5056, must complete outpatient treatment as described in subsection (2) of this section.

(2) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(a) For the first sixty days of treatment:

(i) Conduct group or individual chemical dependency counseling sessions for each patient, each week, according to an individual treatment plan.

(ii) Conduct at least one individual chemical dependency counseling session of no less than thirty minutes duration excluding a chemical dependency assessment for each patient, according to an individual treatment plan.

(iii) Conduct alcohol and drug basic education for each patient.

(iv) Document patient participation in self-help groups described in WAC 388-805-300(16) for patients with a diagnosis of substance dependence.

(v) For patients with a diagnosis of substance dependence who received intensive inpatient chemical dependency treatment services, the balance of the sixty-day time period will consist, at a minimum, of weekly outpatient counseling sessions according to an individual treatment plan.

(b) For the next one hundred twenty days of treatment:

(i) Conduct group or individual chemical dependency counseling sessions for each patient, every two weeks, according to an individual treatment plan.

(ii) Conduct at least one individual chemical dependency counseling session of no less than thirty minutes duration every sixty days for each patient, according to an individual treatment plan.

(c) Upon completion of one hundred eighty days of treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary, using PPC.

(3) For patients who are assessed with insufficient evidence of substance dependence or substance abuse, a CDP must refer the patient to alcohol/drug information school.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-625, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-625, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-625, filed 9/23/03, effective 10/25/03.]

WAC 388-805-630 What are the requirements for outpatient services in a school setting? Any certified chemical dependency service provider may offer school-based services by:

(1) Meeting WAC 388-805-640 requirements; and

(2) Ensuring counseling is provided by a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-630, filed 11/21/00, effective 1/1/01.]

WAC 388-805-640 What are the requirements for providing off-site chemical dependency treatment services? (1) If a certified service provider wishes to offer treatment services, for which the provider is certified, at a site where patients are located primarily for purposes other than chemical dependency treatment, the administrator must:

(a) Ensure off-site treatment services will be provided:

(i) In a private, confidential setting that is discrete from other services provided within the off-site location; and

(ii) By a chemical dependency professional (CDP) or CDP trainee under supervision of a CDP;

(b) Revise agency policy and procedures manuals to include:

(i) A description of how confidentiality will be maintained at each off-site location, including how confidential information and patient records will be transported between the certified facility and the off-site location;

(ii) A description of how services will be offered in a manner that promotes patient and staff member safety; and

(iii) Relevant administrative, personnel, and clinical practices.

(c) Maintain a current list of all locations where off-site services are provided including the name, address (except patient in-home services), primary purpose of the off-site location, level of services provided, and date off-site services began at the off-site location.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-640, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-640, filed 11/21/00, effective 1/1/01.]

WAC 388-805-700 What are the requirements for opiate substitution treatment program providers? An opiate substitution treatment program provider must meet requirements of:

(1) WAC 388-805-001 through 388-805-350;
(2) WAC 388-805-620;
(3) WAC 388-805-700 through 388-805-750; and
(4) 42 Code of Federal Regulations, Part 8.12.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-700, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-700, filed 11/21/00, effective 1/1/01.]

WAC 388-805-710 What are the requirements for opiate substitution medical management? (1) A program physician or authorized health care professional under supervision of a program physician, must provide oversight for determination of opiate physical addiction and conducting a complete, fully documented physical evaluation for each patient before admission.

(2) A medical examination must be conducted on each patient:

(a) By a program physician or other medical practitioner;

(b) Within fourteen days of admission; and

(c) Annually to update the medical examination of each patient by a program physician or other medical practitioner to include the patient's overall physical condition and response to medication.

(3) Prior to initial prescribed dosage of opiate substitution medication, a program physician must ensure that all pregnant patients are provided written and verbal:

(a) Current health information concerning the possible addiction, health risks and benefits opiate substitution medication may have on them and their fetus;

(b) Current health information concerning the risks of not initiating opiate substitution medication may have on them and their fetus and;

(c) Referral options to address neonatal abstinence syndrome for their baby.

(4) Following the patient's initial dose of opiate substitution treatment, the physician must establish adequacy of dose, considering:

(a) Signs and symptoms of withdrawal;

(b) Patient comfort; and

(c) Side effects from over medication.

(5) Prior to the beginning of detox, a program physician must approve an individual detoxification schedule for each patient being detoxified.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-710, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-710, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-710, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-710, filed 11/21/00, effective 1/1/01.]

WAC 388-805-715 What are the requirements for opiate substitution medication management? (1) An opiate substitution treatment program must use only those opioid agonist treatment medications that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opioid addiction.

(2) In addition, an opiate substitution treatment program who is fully compliant with the protocol of an investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized by the Food and Drug Administration under an investigational new drug application under section 505(i) of the Federal Food, Drug, and Cosmetic Act for investigational use in the treatment of opioid addiction. Currently the following opioid agonist treatment medications will be considered to be approved by the Food and Drug Administration for use in the treatment of opioid addiction:

(a) Methadone; and

(b) Buprenorphine distributed as subutex and suboxone.

(3) An opiate substitution treatment program must maintain current procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:

(a) Methadone must be administered or dispensed only in oral form and must be formulated in such a way as to reduce its potential for parenteral abuse;

(b) For each new patient enrolled in a program, the initial dose of methadone must not exceed thirty milligrams and the total dose for the first day must not exceed forty milligrams, unless the program physician documents in the patient's record that forty milligrams did not suppress opiate abstinence symptoms.

(4) An opiate substitution treatment program must maintain current procedures adequate to ensure that each opioid agonist treatment medication used by the program is administered and dispensed in accordance with its approved product labeling. Dosing and administration decisions must be made by a program physician familiar with the most up-to-date product labeling. These procedures must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the patient's record.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-715, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-715, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-715, filed 9/23/03, effective 10/25/03.]

WAC 388-805-720 What are the requirements for drug testing in opiate substitution treatment? (1) The provider must obtain a specimen sample from each patient for drug testing:

(a) At least eight times per year; and

(b) Randomly, without notice to the patient.

(2) Staff must observe the collection of each specimen sample and use proper chain of custody techniques when handling each sample;

(3) When a patient refuses to provide a specimen sample or initial the log of sample numbers, staff must consider the specimen positive; and

(4) Staff must document a positive specimen and discuss the findings with the patient at the next scheduled counseling session.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-720, filed 9/23/03, effective

10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-720, filed 11/21/00, effective 1/1/01.]

WAC 388-805-730 What are the requirements for opiate substitution treatment dispensaries? (1) Each opiate substitution treatment provider must comply with applicable portions of 21 CFR, Part 1301 requirements, as now or later amended.

(2) The administrator must ensure written policies and procedures to verify the identity of patients.

(3) Dispensary staff must maintain a file with a photograph of each patient. Dispensary staff must ensure pictures are updated when:

(a) The patient's physical appearance changes significantly; or

(b) Every two years, whichever comes first.

(4) In addition to notifying the Federal CSAT, SAMHSA and the Federal Drug Enforcement Administration, the administrator must immediately notify the department and the state board of pharmacy of any theft or significant loss of a controlled substance.

(5) The administrator must have a written diversion control plan that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and that assigns specific responsibility to the medical and administrative staff members for carrying out the diversion control measures and functions described in the plan.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-730, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-730, filed 11/21/00, effective 1/1/01.]

WAC 388-805-740 What are the requirements for opiate substitution treatment counseling? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide individual or group counseling sessions once each:

(a) Week, for the first ninety days, for a new patient or a patient readmitted more than ninety days since the person's most recent discharge from opiate substitution treatment;

(b) Week, for the first month, for a patient readmitted within ninety days of the most recent discharge from opiate substitution treatment; and

(c) Month, for a patient transferring from another opiate substitution treatment program where the patient stayed for ninety or more days.

(2) Conduct a treatment plan review once every six months after the second year of continued enrollment in treatment.

(3) A CDP, or a CDP trainee under supervision of a CDP, must provide counseling in a location that is physically separate from other activities.

(4) A pregnant woman and any other patient who requests, must receive at least one-half hour of counseling and education each month on:

(a) Matters relating to pregnancy and street drugs;

(b) Pregnancy spacing and planning; and

(c) The effects of opiate substitution treatment on the woman and fetus, when opiate substitution treatment occurs during pregnancy.

(5) Staff must provide at least one-half hour of counseling on family planning with each patient through either individual or group counseling.

(6) The administrator must ensure there is one staff member who has training in family planning, prenatal health care, and parenting skills.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-740, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-740, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-740, filed 11/21/00, effective 1/1/01.]

WAC 388-805-750 What are the requirements for opiate substitution treatment take-home medications? (1) An opiate substitution treatment provider may authorize take-home medications for a patient when:

(a) The medication is for a Sunday or legal holiday, as identified under RCW 1.16.050; or

(b) Travel to the facility presents a safety risk for patients or staff due to inclement weather.

(2) A service provider may permit take-home medications on other days for a stabilized patient who:

(a) Has received opiate substitution treatment medication for a minimum of ninety days; and

(b) Had negative urines for the last sixty days.

(3) The provider must meet 42 CFR, Part 8.12 (i)(1-5) requirements.

(4) The provider may arrange for opiate substitution treatment medication to be administered by licensed staff or self-administered by a pregnant woman receiving treatment at a certified residential treatment agency when:

(a) The woman had been receiving treatment medication for ninety or more days; and

(b) The woman's use of treatment medication can be supervised.

(5) All exceptions to take-home requirements must be authorized by the state methadone authority.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-750, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-750, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-750, filed 11/21/00, effective 1/1/01.]

WAC 388-805-800 What are the requirements for ADATSA assessment services? (1) An agency certified to conduct ADATSA assessments must conduct the assessment for each eligible patient and be governed by the requirements under:

(a) WAC 388-805-001 through 388-805-310;

(b) WAC 388-805-020 and 388-805-325 (1), (2), (3), (4), (5), (9), (15), (16), 388-805-330; and 388-805-350; and

(c) Chapter 388-800 WAC.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-800, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-800, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-800, filed 11/21/00, effective 1/1/01.]

WAC 388-805-810 What are the requirements for DUI assessment providers? (1) If located in a district or municipal probation department, each DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-135,

(b) WAC 388-805-145 (4), (5), and (6);

(c) WAC 388-805-150, the administrative manual, subsections (4), (7) through (11), (13), and (14);

(d) WAC 388-805-155, facilities, subsections (1)(b), (c), (d), and (2)(b);

(e) WAC 388-805-200 (1), (4), and (5);

(f) WAC 388-805-205 (1), (2), (3)(a) through (d), (4), (5), and (7);

(g) WAC 388-805-220, 388-805-225, and 388-805-230;

(h) WAC 388-805-260, volunteers;

(i) WAC 388-805-300, clinical manual, subsections (1), (2), (3), (9), (20), (21), and (22);

(j) WAC 388-805-305, patients' rights;

(k) WAC 388-805-310, assessments;

(l) WAC 388-805-320, patient record system, subsections (3)(a) through (f), and (5);

(m) WAC 388-805-325, record content, subsections (1), (2), (3), (4), (5), (7), (8), (10), (15), (16), and (17); and

(n) WAC 388-805-350, outcomes evaluation.

(2) If located in another certified chemical dependency treatment facility, the DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-260; 388-805-305 and 388-805-310; and

(b) WAC 388-805-300, 388-805-320, 388-805-325 as noted in subsection (1) of this section, 388-805-350.

(3) Providers must limit patients to persons who have been arrested for a violation of driving under the influence of intoxicating liquor or other drugs or in physical control of a vehicle as defined under chapter 46.61 RCW.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-810, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-810, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-810, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-810, filed 11/21/00, effective 1/1/01.]

WAC 388-805-820 What are the requirements for alcohol and other drug information school? (1) Alcohol and other drug information school providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The provider must:

(a) Inform each student of fees at the time of enrollment; and

(b) Ensure adequate and comfortable seating in well-lit and ventilated rooms.

(3) A certified information school instructor or a chemical dependency professional must teach the course and:

(a) Advise each student there is no assumption the student is an alcoholic or drug addict, and this is not a therapy session;

(b) Discuss the class rules;

(c) Review the course objectives;

(d) Follow curriculum contained in "Alcohol and Other Drugs Information School Training Curriculum," published in 2001, or later amended;

(e) Ensure not less than eight and not more than fifteen hours of class room instruction;

(f) Administer the posttest from the above reference to each enrolled student after the course is completed;

(g) Ensure individual student records include:

(i) Intake form;

(ii) Hours and date or dates in attendance;

(iii) Source of referral;

(iv) Copies of all reports, letters, certificates, and other correspondence;

(v) A record of any referrals made; and

(vi) A copy of the scored posttest.

(h) Complete and submit reports required by the courts and the department of licensing, in a timely manner.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-820, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-820, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-820, filed 11/21/00, effective 1/1/01.]

WAC 388-805-830 What are the requirements for information and crisis services? (1) Information and crisis service providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The information and crisis service administrator must:

(a) Ensure a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, is available or on staff;

(b) Maintain a current directory of certified chemical dependency service providers in the state;

(c) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services;

(d) Have services available twenty-four hours a day, seven days a week;

(e) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:

(i) Chemical dependency crisis intervention techniques;

(ii) Alcoholism and drug abuse; and

(iii) Prevention and control of TB and bloodborne pathogens.

(f) Have policies and procedures for provision of emergency services, by phone or in person, to a person incapacitated by alcohol or other drugs, or to the person's family, such as:

(i) General assessments;

(ii) Interviews for diagnostic or therapeutic purposes;

(iii) Crisis counseling; and

(iv) Referral.

(g) Maintain records of each patient contact, including:

(i) The presenting problem;

(ii) The outcome;

(iii) A record of any referral made;

(iv) The signature of the person handling the case; and

(v) The name, age, sex, and race of the patient.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-830, filed 11/21/00, effective 1/1/01.]

WAC 388-805-840 What are the requirements for emergency service patrol? (1) The emergency service patrol provider must ensure staff providing the service:

(a) Have proof of a valid Washington state driver's license;

(b) Possess annually updated verification of first-aid and cardiopulmonary resuscitation training;

(c) Have completed forty hours of training in chemical dependency crisis intervention techniques, and alcoholism and drug abuse, to improve skills in handling crisis situations; and

(d) Have training on communicable diseases, including:

(i) TB prevention and control; and

(ii) Bloodborne pathogens such as HIV/AIDS and hepatitis.

(2) Emergency service patrol staff must:

(a) Respond to calls from police, merchants, and other persons for assistance with an intoxicated person in a public place;

(b) Patrol assigned areas and give assistance to a person intoxicated in a public place; and

(c) Conduct a preliminary assessment of a person's condition relating to the state of inebriation and presence of a physical condition needing medical attention:

(i) When a person is intoxicated, but subdued and willing, transport the person home, to a certified treatment provider, or a health care facility;

(ii) When a person is incapacitated, unconscious, or has threatened or inflicted harm on another person, staff must make reasonable efforts to:

(A) Take the person into protective custody; and

(B) Transport the person to an appropriate treatment or health care facility.

(3) Emergency service patrol staff must maintain a log including:

(a) The time and origin of each call received for assistance;

(b) The time of arrival at the scene;

(c) The location of the person at the time of the assist;

(d) The name and sex of the person transported;

(e) The destination of the transport and time of arrival; and

(f) In case of nonpickup of a person, a notation must be made about why the pickup did not occur.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-840, filed 11/21/00, effective 1/1/01.]

WAC 388-805-855 What are the requirements for screening and brief intervention services? (1) Screening and brief intervention service providers must be governed under:

(a) WAC 388-805-001 through 388-805-135, 388-805-205 and 388-805-640; and

(b) This section.

(2) The screening and brief intervention administrator must:

(a) Ensure a chemical dependency professional (CDP), or a CDP trainee under the supervision of a CDP, provides the services;

(b) Maintains a current list of local resources for legal, employment, education, interpreter, and social and health services;

(c) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:

(i) Chemical dependency screening and brief intervention techniques; and

(ii) Motivational interviewing.

(d) Have policies and procedures for the provision of screening and brief intervention services, such as:

(i) Screening;

(ii) Motivational interviewing; and

(iii) Referral.

(e) Ensure the individual patient records contain:

(i) A copy of a referral;

(ii) Demographic information;

(iii) Documentation the patient was informed and received a copy of the requirements under 42 C.F.R Part 2;

(iv) Documentation the patient received a copy of the counselor disclosure information;

(v) Documentation the patient received a copy of the patient rights;

(vi) Properly completed authorization for the release of information;

(vii) A copy of screening documents including outcome and referrals; and

(viii) Progress notes summarizing any contact with the patient.

[Statutory Authority: RCW 70.96A.040, chapter 70.96A RCW, and 42 C.F.R. Part 8. 08-24-083, § 388-805-855, filed 12/1/08, effective 1/1/09.]

Chapter 388-810 WAC

ADMINISTRATION OF COUNTY CHEMICAL DEPENDENCY PREVENTION, TREATMENT, AND SUPPORT PROGRAM

(Formerly chapter 440-25 WAC)

WAC

WAC 388-810-005 What is the purpose of this chapter? The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency preven-

tion, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

WAC 388-810-010 What definitions apply to this chapter?

"County" means each county or two or more counties acting jointly.

"County chemical dependency program coordinator" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"County chemical dependency prevention, treatment, and support program" means services and activities funded by the department through a negotiated contract between a county and the department.

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

"Designated chemical dependency specialist" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator? A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist? A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18.205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program? (1) DSHS determines the service priorities for services funded by the department.

(2) DSHS must inform the county of the service priorities during the contract negotiation process.

(3) Counties must follow DSHS's service priorities when delivering chemical dependency program services supported by department funds.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-040, filed 9/20/99, effective 10/21/99.]

WAC 388-810-050 How are available funds allocated for the county chemical dependency program? (1) For the purposes of this section, "county" means the legal subdivision of the state, regardless of any agreement between two counties.

(2) The department shall allocate the funds available to the counties through funding formulas jointly developed with representatives of the counties, to carry out the intent of the federal and state legislated appropriations including any budget provisos.

(3) For information on current funding formulas, contact: Chief Financial Officer, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington 98504-5330, Telephone: (360) 438-8088.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-050, filed 9/20/99, effective 10/21/99.]

WAC 388-810-060 How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program? A county may not use more than ten percent of the chemical dependency prevention, treatment, and support program funds managed by the county for administering the program.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-060, filed 9/20/99, effective 10/21/99.]

WAC 388-810-070 How will funds be made available to the county? (1) DSHS and each county negotiates and executes a county contract before the department reimburses the county for chemical dependency prevention, treatment, and support program services.

(2) DSHS may authorize the county to continue providing services according to a previous county contract and reimburse at the average level of the previous contract, in order to continue services until the department executes a new contract.

(3) DSHS may make advance payments to a county, if the payments facilitate sound program management.

(4) DSHS may require fiscal and program reports.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-070, filed 9/20/99, effective 10/21/99.]

WAC 388-810-080 May a county subcontract for chemical dependency prevention, treatment, and support services? A county may subcontract for services specified in the contract.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-080, filed 9/20/99, effective 10/21/99.]

WAC 388-810-090 How does a county request an exemption? (1) A county may request an exemption to these rules by sending a written request to the department.

(2) DSHS may grant an exemption if the department's assessment of the exemption request:

(a) Ensures the exemption does not undermine the legislative intent of chapter 70.96A RCW; and

(b) Shows that granting the exemption does not adversely affect the quality of the services, supervision, health, and safety of department customers.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-090, filed 9/20/99, effective 10/21/99.]

Chapter 388-818 WAC
DEAF AND HARD OF HEARING SERVICES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-818-001 Scope. [99-20-022, recodified as § 388-818-001, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-002 Regional centers. [99-20-022, recodified as § 388-818-002, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-003 Services. [99-20-022, recodified as § 388-818-003, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effec-

tive 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-005 Definitions. [99-20-022, recodified as § 388-818-005, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-010 Eligibility requirements. [99-20-022, recodified as § 388-818-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-020 Approval of application for initial device or request for replacement device. [99-20-022, recodified as § 388-818-020, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-030 Denial of initial application or request for replacement device. [99-20-022, recodified as § 388-818-030, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-040 Application renewal process. [99-20-022, recodified as § 388-818-040, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-050 Notice of approval or denial. [99-20-022, recodified as § 388-818-050, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-060 Review by department. [99-20-022, recodified as § 388-818-060, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-070 Distribution. [99-20-022, recodified as § 388-818-070, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-080 Training. [99-20-022, recodified as § 388-818-080, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-090 Ownership and liability. [99-20-022, recodified as § 388-818-090, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-110 Telecommunications relay service. [99-20-022, recodified as § 388-818-110, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

388-818-130 Uses for returned equipment. [99-20-022, recodified as § 388-818-130, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

PURPOSE

WAC 388-818-0010 What is the purpose of this chapter? (1) The purpose of this chapter is to provide regulations about social and telecommunications access services for people with hearing loss and speech impairments.

(2) These services are provided:

(a) Under contract with qualified service providers; or

(b) Directly through the office of the deaf and hard of hearing (ODHH) at the department of social and health services (DSHS).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0010, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0020 What does the office of the deaf and hard of hearing do? (1) The office of the deaf and hard of hearing (ODHH) within DSHS provides the following services to DSHS staff:

(a) Provides information about hearing loss;

(b) Offers technical assistance and workshops about deafness; and

(c) Identifies ways for DSHS staff to get sign language interpreter services for their clients who have hearing loss.

(2) ODHH administers and monitors contracts with qualified service providers. These service providers offer community-based social services for clients who have hearing loss.

(3) ODHH manages the telecommunications access service program.

(4) ODHH contracts to provide telecommunications relay services (TRS).

(5) ODHH facilitates the DSHS-telecommunications relay services (TRS) advisory committee on deafness.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0020, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0030 What does the telecommunications access service do? Telecommunications access service (TAS), a program within ODHH:

(1) Provides eligible clients with initial or replacement equipment, based on the availability of equipment and/or funds;

(2) Maintains and oversees the statewide program for distributing telecommunications equipment;

(3) Maintains and oversees the contract for TRS; and

(4) May contract with qualified service providers for other telecommunications options as technology advances.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0030, filed 2/19/03, effective 3/22/03.]

DEFINITIONS

WAC 388-818-0040 What definitions apply to this chapter? "Amplified telephone" means an electrical device that increases the volume or tone of sounds being received during a telephone call.

"Applicant" means a client who applies for specialized telecommunications equipment.

"Audiologist" means a person who has a certificate of clinical competence in audiology from the American Speech, Hearing, and Language Association and is licensed to practice in the state of Washington.

"Client" means a person who is deaf, hard of hearing, speech impaired, or deaf-blind and may receive services from ODHH.

"Deaf" means a condition where a person's hearing ability is absent or mostly absent.

"Deaf-blind" means a person with both hearing loss and visual impairments.

"DSHS or department" means the department of social and health services.

"Federal poverty guidelines" means the poverty level established by the **"Poverty Income Guideline"** updated annually in the Federal Register.

"Hearing loss" means any form of hearing impairment, from mild to profound.

"Mobility impairment" for the purpose of this chapter means restricted upper body movement, which limits the ability to hold or dial a standard telephone to communicate. Individuals must also have a hearing loss or speech impairment.

"ODHH" means the office of the deaf and hard of hearing in the department of social and health services.

"Qualified service provider" means an agency or a business that provides social services to individuals with hearing loss or speech impairments. A qualified service provider may also be a **"qualified trainer."**

"Qualified trainer" means a person under contract with TAS who is knowledgeable in the use of telecommunications equipment.

"Relay service" is defined under **"telecommunications relay service (TRS)."**

"School-age" means between four and seventeen years of age.

"Sliding fee scale" means a range used to determine an applicant's participation in the cost of equipment.

"Speech impairment" means inability to speak or a speech disability.

"TAS" means the telecommunications access service program administered by the office of the deaf and hard of hearing. The program provides equipment and services to help people with hearing loss and speech impairments have equal access to telecommunications.

"Telecommunications equipment" means any specialized device determined by TAS in ODHH to help a person with a hearing loss or speech impairment to communicate effectively. Examples include: Amplified telephone, TTY, signaling devices, software, digital equipment, and accessories. (See WAC 388-818-0070.)

"Telecommunications relay service (TRS)" means wire or radio service that enables a person with hearing loss or speech impairment to communicate with a person who uses a voice telephone. This service has communication assistants who transfer telephone conversations from one format to another (such as spoken words to text) to facilitate communication between two or more people.

"TTY" means teletypewriter or text telephone.

"TTY with Braille" means a teletypewriter with Braille keyboard and display.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0040, filed 2/19/03, effective 3/22/03.]

SOCIAL SERVICES FOR CLIENTS WITH HEARING LOSS

WAC 388-818-0050 What social services relating to hearing loss are available to the public? (1) These social services relating to hearing loss are offered by qualified service providers and ODHH staff throughout the state:

(a) Information and referral about issues related to hearing loss;

(b) Advocacy on behalf of people with hearing loss;

(c) Training on deaf awareness and daily living issues experienced by people with hearing loss;

(d) Social gathering opportunities for groups, organizations, and clubs related to people with hearing loss; and

(e) Services related to telecommunications equipment, distribution of equipment, and training on the use and care of equipment.

(2) Qualified service providers offer these services to:

(a) Washington residents with hearing loss;

(b) The general public for information about hearing loss; and

(c) Telephone users who need their conversations relayed, or transferred from one format to another (such as spoken words to text).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0050, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0060 Who are qualified service providers? Qualified service providers are organizations or businesses that contract with ODHH to provide social services related to hearing loss. Examples of qualified service providers include: Regional deaf and hard of hearing centers, relay service providers, and trainers for telecommunication equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0060, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT

WAC 388-818-0070 Is telecommunications equipment available for clients? (1) Clients may request telecommunications equipment from TAS.

(2) For clients to receive equipment, TAS staff must approve equipment requests.

(3) To be approved, telecommunications equipment must help people with hearing loss or speech impairments to:

(a) Have independent use of telecommunications equipment; and

(b) Gain equal access to telecommunications services that people with normal hearing and speech have.

(4) Specialized equipment may include: Text, amplification, video, and hands-free equipment as well as ring signaling devices.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0070, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0080 What items are not included with telecommunications equipment? In the use of telecommunications equipment, neither TAS nor contracted qualified service providers offer:

(1) Replacement batteries for any telecommunications equipment, except for deaf-blind equipment;

(2) Replacement paper for TTYs;

(3) Replacement light bulbs for signal equipment; or

(4) Payment of the client's telephone bill.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0080, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—APPLICATION PROCESS

WAC 388-818-0090 Who is eligible to apply for telecommunications equipment from TAS? (1) Washington state residents may apply to receive telecommunications equipment from TAS if they:

(a) Are at least school aged; and

(b) Are certified as having hearing loss or speech impairments.

(2) Nonprofit organizations may apply to receive telecommunications equipment, as specified under WAC 388-818-0180.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0090, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0100 Who must certify an applicant's eligibility for telecommunications equipment from TAS? (1) A professional must certify that applicants have hearing loss and/or speech impairments and are eligible to receive telecommunications equipment from TAS.

(2) These professionals include:

(a) A person who is licensed or certified by the department of health to provide health care in the state of Washington;

(b) An audiologist or hearing aid fitter/dispenser in Washington;

(c) A vocational rehabilitation counselor;

(d) A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;

(e) A deaf-blind specialist or coordinator at an organization that serves deaf-blind people;

(f) A certified speech pathologist practicing in the state of Washington;

(g) A licensed occupational therapist;

(h) Staff from a qualified state agency as determined and specified by the TRS advisory committee on deafness; or

(i) Any in-state nonprofit organization serving the hearing or speech impaired.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0100, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0110 How do applicants request specialized telecommunications equipment? (1) To request specialized telecommunications equipment, an applicant must send a completed "Application for Telecommunications Equipment" form (DSHS 14-264) to TAS. To request an application, contact ODHH at 1-800-422-7930 V/TTY.

(2) The application form must be signed by an approved professional who certifies applicant's eligibility. (See WAC 388-818-0100.)

(3) If the applicant is seventeen or under, his or her parent/legal guardian must sign the application form.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0110, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0120 What types of income are included when requesting equipment from TAS? To meet income standards for telecommunications equipment from TAS, an applicant's income includes any of the following:

(1) Earned income, such as wages and tips;

(2) Social Security benefits;

(3) Unearned income, such as interest, dividends, and pensions;

(4) Family's share of income from corporations, partnerships, estates, and trusts; and

(5) Gains from the sale or exchange (including barter) of real estate, securities, coins, gold, silver, gems, or other property.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0120, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0130 How are applicants notified about decisions for telecommunications equipment? (1) When approving an application for telecommunications equipment, TAS staff must inform the applicant in writing about:

(a) The receipt of the applicant's completed application form;

(b) Any cost that applicants will incur for equipment; and

(c) The time frame when the applicant may expect a qualified trainer to set up the equipment and provide training.

(2) When denying an application for telecommunications equipment, TAS must inform the applicant in writing about:

(a) The receipt of the applicant's completed application form;

(b) The reasons for the denial; and

(c) Any applicable procedures for appeal, as well as the circumstances under which the applicant may reapply. (See WAC 388-818-0150.)

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0130, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0140 What are reasons for denying telecommunications equipment? (1) For an initial application for services, TAS must deny an application for telecommunications equipment if an applicant:

(a) Does not meet the eligibility requirements of WAC 388-818-0090; or

(b) Has received similar equipment from TAS within the last three years.

(2) For an application requesting replacement of telecommunications equipment, TAS must deny the request if the client has done any of the following:

(a) Abused, misused, or repaired without approval any previously issued equipment;

(b) Failed to file with the police a report of stolen equipment within fifteen working days of discovering a theft;

(c) Failed to file with the police or the fire department a report of fire having damaged the equipment within fifteen working days of the incident of the fire;

(d) Lost, pawned, or sold the equipment; or

(e) Failed to obtain approval from DSHS before moving or traveling out of state with state-loaned equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0140, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—APPLICATION RENEWAL

WAC 388-818-0150 When may clients renew their applications for telecommunications equipment? Clients may renew their applications for telecommunications equipment when:

(1) Additional telecommunication equipment is necessary to meet the client's needs; or

(2) Equipment no longer works and it's been more than three years since he or she first received equipment.

Note: If less than three years have passed since a client first received equipment, refer to WAC 388-818-0300 for replacement criteria.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0150, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0160 How do clients renew their application for telecommunications equipment? When renewing an application for telecommunications equipment, a client must:

(1) Complete a new application, including recent information on total annual family income and family size; and

(2) Go through the same procedures as first-time applicants (outlined in WAC 388-818-0090 through 388-818-0130).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0160, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—NONPROFIT ORGANIZATIONS

WAC 388-818-0170 Are nonprofit organizations eligible for telecommunications equipment? (1) A nonprofit organization may be eligible for telecommunications equipment when these two criteria are met:

(a) Only nonprofit organizations under section 501 (c)(3) of the internal revenue code, are eligible for any equipment from TAS; and

(b) Nonprofit organizations must serve people with hearing loss, deaf-blindness, and/or speech impairments.

(2) A qualified nonprofit organization is eligible to receive:

(a) Reconditioned telecommunications equipment from ODHH; or

(b) New equipment when it is in the best interest of both ODHH and the individuals served by the nonprofit organization.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0170, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0180 What process do nonprofit organizations follow to receive telecommunications equipment from TAS? (1) To apply for reconditioned equipment, a nonprofit organization must provide to TAS the following:

(a) A completed application form, "Nonprofit Organization Application for Reconditioned Equipment" (DSHS 14-440), which can be obtained by calling ODHH at 1-800-422-7930;

(b) A letter explaining the services provided by the organization to people with hearing loss and speech impairments in their communities;

(c) A copy of a certificate of incorporation as a nonprofit organization under section 501 (c)(3) of the internal revenue code; and

(d) A copy of the organization's bylaws.

(2) TAS staff notifies the nonprofit organization of acceptance or denial.

(3) TAS staff sends the equipment to an approved nonprofit organization.

(4) The nonprofit organizations are responsible for care and maintenance of this equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0180, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—PURCHASE AND LOAN

WAC 388-818-0190 How much does an applicant have to pay for telecommunications equipment? (1) TAS staff must consider family size and household income in determining how much the applicant must pay for telecommunications equipment. Financial responsibility ranges from no cost to one hundred percent of actual cost based on federal poverty guidelines.

(2) Exception: If the normal cost that TAS assesses for equipment is still beyond the applicant's ability to pay, the cost may be partly or totally waived (excused) if:

(a) The eligible person requires TTY with Braille equipment or any other equipment of comparable cost; or

(b) The cost of the equipment would create an undue hardship on the eligible person.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0190, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0200 How does an applicant request a waiver (exception) of equipment cost? (1) To request a waiver (exception) of equipment cost, an applicant must write a letter to the ODHH director explaining the reasons for inability to pay for equipment. Letters can be mailed to: ODHH, Attn: Director, P.O. Box 45301, Olympia WA 98504-5301.

(2) ODHH notifies the applicant in writing of the final decision for the waiver request.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0200, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0210 What conditions must be met for a client to receive purchased telecommunication equipment? For a client to receive purchased telecommunications equipment, these two conditions must be met:

(1) TAS must receive full payment before an eligible client receives telecommunications equipment; and

(2) The applicant or the applicant's parent/legal guardian must provide a signed "Statement of Rights and Responsibilities" form to TAS upon receiving the equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0210, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0220 When is telecommunications equipment owned by the client? Telecommunications equipment is owned by the client when the client or the parent/legal guardian:

(1) Pay any portion of the equipment's cost; and

(2) Sign a "Statement of Rights and Responsibilities" form upon receiving the equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0220, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0230 May clients return purchased telecommunications equipment? (1) A client may return purchased telecommunications equipment to TAS within thirty days after receiving the equipment.

(2) A client must receive a financial refund for the equipment if it was returned:

(a) In clean and good condition;

(b) In its original packaging; and

(c) Within the required time frame.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0230, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0240 When may telecommunications equipment be loaned to an applicant? ODHH may loan telecommunications equipment to an eligible person if:

(1) TAS determines that a client may get equipment at no cost;

(2) A "Conditions of Acceptance" form is signed by the client or the parent/legal guardian upon receiving the equipment.

(3) The applicant has not violated the requirements in WAC 388-818-0140(2).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0240, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0250 What are the conditions for loaning telecommunications equipment? (1) When loaning telecommunications equipment, ODHH must ensure that the client understands that the equipment remains the sole property of Washington state.

(2) A client, or the client's parent/legal guardian is liable for any damage to or loss of telecommunications equipment issued by TAS.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0250, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0260 When does state-loaned equipment have to be returned to TAS? A client or the client's parent/legal guardian must return state-loaned telecommunications equipment to TAS when the client:

(1) Moves from a permanent Washington state residence to a location outside of Washington;

(2) No longer needs the equipment;

(3) Has been notified by TAS to return the equipment; or

(4) Has received new state-loaned equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0260, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0270 May a person take loaned telecommunications equipment outside the state? (1) People must get written permission from TAS before moving their loaned telecommunications equipment from Washington state for over ninety days.

(2) TAS may grant the client permission to move telecommunications equipment from the state if it is in the best interest of the client and DSHS.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0270, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—TRAINING

WAC 388-818-0280 Will training be provided on the use and care of telecommunications equipment? (1) ODHH contracts with qualified people or agencies to train individuals on ways to use and care for telecommunications equipment provided by TAS.

(2) ODHH must ensure reasonable accessibility to training for people with hearing loss or speech impairment.

(3) ODHH staff determine who receives training on proper equipment use and care from qualified trainers. Individuals receiving training may include:

(a) Clients;

(b) Parents/legal guardians; and

(c) Staff or volunteers of profit and nonprofit organizations.

(4) When applicants are age seventeen or younger, their parents/legal guardians must attend all training sessions on appropriate equipment use and care.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0280, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0290 What services do trainers provide to clients? (1) Qualified trainers must determine the training needs of individuals and the type of training that would be most effective.

(2) A qualified trainer must:

(a) Conduct individual and group training sessions for the applicants in the use and care of the equipment;

(b) Provide training and presentations to individuals, agencies and organizations, as requested by ODHH staff; and

(c) Distribute and set up telecommunications equipment for applicants.

(3) When delivering telecommunications equipment, a qualified trainer may decide that the purchased equipment does not meet the client's needs. In this case, the trainer may recommend other equipment to the client. If accepting other equipment, the client must take financial responsibility for any cost difference by signing an "Acceptance of Financial Responsibility" form.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0290, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATION EQUIPMENT—REPLACEMENT

WAC 388-818-0300 When may telecommunications equipment be replaced? (1) TAS may replace telecommunications equipment without a client renewing the application for equipment if:

(a) The equipment is no longer working; and

(b) Less than three years have passed since the client's initial application date for equipment.

(2) Clients may renew their application with TAS to replace telecommunications equipment if:

(a) The equipment is no longer working; and

(b) Three years have passed from the last time they applied and received their equipment. (See WAC 388-818-0160 for the renewal process.)

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0300, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0310 When may requests for replacement telecommunications equipment be denied? TAS may deny a request for replacement telecommunications equipment if previously issued equipment:

(1) Was neglected, misused, or abused;

(2) Was not reported as stolen or burned to either police or fire department within fifteen working days; or

(3) Was lost, sold, traded, or pawned.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0310, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATION EQUIPMENT—RECONDITIONED

WAC 388-818-0320 Who may receive reconditioned telecommunications equipment? TAS may recondition telecommunications equipment and give it to any of the following agencies, nonprofit organizations or individuals:

(1) State agencies;

(2) Tribal community centers;

(3) Nonprofit organizations that are registered under section 501 (c)(3) of the internal revenue code and serve people who have hearing loss, deaf-blindness or speech impairment (see WAC 388-818-0180 for application details); and

(4) Nonpaying clients.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0320, filed 2/19/03, effective 3/22/03.]

GRIEVANCE

WAC 388-818-0330 May an applicant disagree with a DSHS decision about telecommunications equipment? (1) When TAS denies an application for original or replacement equipment, an applicant or client may request that ODHH review this decision.

(2) For a review of a TAS decision, the applicant or client must:

(a) Submit a request in writing to ODHH, specifying the reason for the request; and

(b) Ensure that ODHH receives this request within forty days of the date of the denial notice.

(3) Within thirty days after receiving the request for review, ODHH staff must inform the applicant or client in writing of the decision of the request. The decision of ODHH is final.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0330, filed 2/19/03, effective 3/22/03.]

GRIEVANCE—RELAY SERVICES

WAC 388-818-0340 What is a relay complaint? (1) A client may make a complaint about an unsatisfactory experience while using the relay services during a telephone call. Complaints may be about:

(a) Communications assistant (CA) or video interpreter (VI) performance, such as typing speed, accuracy of relaying a message's intent, clarity of signs, and spelling accuracy;

(b) Service quality, such as timeliness of response and connection; and/or

(c) Technical issues during a call made through the relay service, such as disconnection of call, video picture quality, or text garbling.

(2) The main purpose of a relay complaint is to:

(a) Improve the quality of relay service; and

(b) Monitor relay agent or interpreter performance and the accuracy of relaying information between calling parties.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0340, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0350 What may a client do when dissatisfied with relay services? (1) ODHH must ensure that clients have access to customer services for the relay service provider or an opportunity to resolve quality of service issues with TRS regarding:

(a) Any problems with the relay service; and/or

(b) Dissatisfaction with explanations given for any relay service problems.

(2) To assist dissatisfied clients, the ODHH compliance officer must provide names and telephone numbers for customer support.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0350, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0360 May a client file a formal complaint about the relay service? (1) A client may file a formal complaint about the relay service:

(a) To obtain a complaint form about the relay service, a client may contact ODHH (at 1-800-422-7930) to request that a form be mailed.

(b) The client may also contact the ODHH compliance officer or relay provider customer service representative for assistance in completing the form.

(c) Completed complaint forms may be mailed, faxed, or e-mailed to ODHH.

(2) ODHH must investigate and resolve the complaint within one hundred eighty days, as required by the Federal Communications Commission (FCC).

(a) Complaints related to service issues are resolved by the relay service provider and the compliance officer.

(b) Technical complaints are referred to relay service provider technical personnel for resolution.

(c) Any corrective action must be taken as soon as possible.

(d) The ODHH compliance officer must notify the client about the result of the investigation, including any actions taken.

(3) If the client is satisfied with the results of the investigation, the ODHH compliance officer must document and close the case.

(4) If the client is dissatisfied with the results of the investigation, the compliance officer and relay service provider may discuss further options to resolve the complaint and corrective actions.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0360, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0370 When is customer service available for clients? The relay service provider and ODHH must ensure that customer service is available during regular work days (Monday through Friday excluding state holidays) to:

(1) Address client complaints or inquiries; and

(2) Respond to FCC staff members when requested.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0370, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0380 May clients file their complaint about relay services with the FCC? (1) A client who continues to be dissatisfied with responses from the formal complaint process at ODHH may file a complaint with the Federal Communications Commission (FCC).

(2) The ODHH compliance officer must give the client the toll-free telephone number and address of the FCC for further review of the complaint.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0380, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0390 May the FCC file a complaint? (1) The FCC may file a complaint to ODHH or the relay service provider.

(2) Within one hundred eighty days of receiving the complaint, ODHH must:

(a) Report the results of the complaint investigation to the FCC; or

(b) Keep the FCC informed about ongoing progress of actions toward resolution.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0390, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0400 What documents must ODHH keep for complaints? (1) ODHH must keep a record of all complaints about the quality of relay services.

(2) The complaint document must show at least:

(a) The name, phone number and address of the complainant;

(b) The nature and date of the complaint;

(c) Actions taken; and

(d) The final disposition of the complaint.

(3) These records must be maintained in a suitable place, readily available for FCC review.

(4) ODHH and the relay service provider must retain correspondence and records of complaints for a minimum of two years.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0400, filed 2/19/03, effective 3/22/03.]

Chapter 388-823 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES INTAKE AND DETERMINATION OF DEVELOPMENTAL DISABILITIES

WAC

APPLYING FOR A DETERMINATION OF A DEVELOPMENTAL DISABILITY

WAC 388-823-0010 Definitions. The following definitions apply to this chapter:

"Client" means a person with a developmental disability as defined in chapter 388-823 WAC who is currently eligible and active with the division of developmental disabilities.

"DAS" means differential ability scales, which is a cognitive abilities battery for children and adolescents at least age two years, six months but under age eighteen.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration, department of social and health services.

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

"Division" means the division of developmental disabilities.

"Eligible" means you have a developmental disability that meets all of the requirements in this chapter for a specific condition.

"Expiration date" means a specific date that your eligibility as a client of DDD and all services paid by DDD will stop.

"FSIQ" means the full scale intelligence quotient which is a broad measure of intelligence achieved through one of the standardized intelligence tests included in these rules. Any standard error of measurement value will not be taken into consideration when making a determination for DDD eligibility.

"ICAP" means the inventory for client and agency planning. This is a standardized assessment of functional ability. The adaptive behavior section of the ICAP assesses daily living skills and the applicant awareness of when to perform these skills. The goal is to get a snapshot of his/her ability.

"IMR" means an institution for the mentally retarded, per chapter 388-835 WAC or chapter 388-837 WAC.

"K-ABC" means Kaufman assessment battery for children, which is a clinical instrument for assessing intellectual development. It is an individually administered test of intelligence and achievement for children at least age two years, six months but under age twelve years, six months. The K-ABC comprises four global scales, each yielding standard scores.

A special nonverbal scale is provided for children at least age four years but under age twelve years, six months.

"Leiter-R" means Leiter international performance scale - revised, which is an untimed, individually administered test of nonverbal cognitive ability for individuals at least age two years but under age twenty-one years.

"Review" means DDD must redetermine that you still have a developmental disability according to the rules that are in place at the time of the review.

"RHC" means one of five residential habilitation centers operated by the division: Lakeland Village, Yakima Valley School, Fircrest, Rainier School, and Francis Haddon Morgan Center.

"SIB-R" means the scale of independent behavior-revised which is an adaptive behavior assessment derived from quality standardization and norming. It can be administered as a questionnaire or as a carefully structured interview, with special materials to aid the interview process.

"SOLA" means a state operated living alternative residential service for adults operated by the division.

"Stanford-Binet" is a battery of fifteen subtests measuring intelligence for individuals at least age two years but under age twenty-three years.

"Termination" means an action taken by DDD that stops your DDD eligibility and services paid by DDD.

"VABS" means Vineland adaptive behavior scales, which is an assessment to measure adaptive behavior in children from birth but under age eighteen years, nine months and in adults with low functioning in four separate domains: Communication, daily living skills, socialization, and motor skills.

"Wechsler" means the Wechsler intelligence scale, which is an individually administered 11-subtest measure of an individual's capacity for intelligent behavior. The Wechsler has both a verbal scale and a performance scale. The Wechsler is used with individuals at least age three years but under age seventy-four years. The verbal scale can be used alone with individuals who have visual or motor impairments, and the performance scale can be used alone with individuals who cannot adequately understand or produce spoken language. There are three Wechsler intelligence scales, dependent upon the age of the individual:

• The Wechsler preschool and primary scale of intelligence - revised (WPPSI-R), for children at least age three years but under age seven years;

• The Wechsler intelligence scale for children - third edition, (WISC-III), for children at least age six years but under age sixteen years; and

• The Wechsler adult intelligence scale - revised (WAIS-R), for individuals at least age sixteen years but under age seventy-four years.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0010, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0020 How do I become a client of the division of developmental disabilities? You become a client of the division of developmental disabilities (DDD) if you apply for eligibility with DDD and DDD determines that you have a "developmental disability" as defined in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0020, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0030 Will I receive paid services if DDD decides that I have a developmental disability? If DDD determines that you have a developmental disability, your access to paid services as a DDD client depends on:

(1) Your meeting eligibility requirements for the specific service;

(2) An assessed need for the service; and

(3) Available funding for the service. The availability of funding does not apply to medicaid state plan services or services available under the DDD medicaid home and community based services waiver.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0030, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0040 What is a developmental disability? (1) A developmental disability is defined in RCW 71A.10.020(3) and must meet all of the following requirements. The developmental disability must currently:

(a) Be attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDD to be closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation;

(b) Originate prior to age eighteen;

(c) Be expected to continue indefinitely; and

(d) Result in substantial limitations to an individual's adaptive functioning.

(2) In addition to the requirements listed in (1) above, you must meet the other requirements contained in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0040, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0050 Must I be a resident of the state of Washington? When you apply for eligibility with DDD, you must be a resident of the state of Washington. Proof of residency includes:

(1) The receipt of medicaid or other benefits from the department of social and health services that require residency as a condition of eligibility; or

(2) Documentation that shows you live in the state of Washington, or, if you are a child under the age of eighteen, documentation that shows your parent or legal guardian lives in the state of Washington.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0050, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0060 How do I apply to become a client of DDD? (1) You apply to become a client of DDD by calling the regional DDD office or a local DDD office and

requesting determination of a developmental disability. The toll free regional numbers are:

Region 1	Spokane	1-800-462-0624
Region 2	Yakima	1-800-822-7840
Region 3	Everett Bellingham Mount Vernon	1-800-788-2053 1-800-239-8285 1-800-491-5266
Region 4	Seattle	1-800-314-3296
Region 5	Tacoma Bremerton	1-800-248-0949 1-800-735-6740
Region 6	Port Angeles Tumwater Vancouver	1-877-601-2760 1-800-339-8227 1-888-877-3490

(2) DDD will make arrangements with you to complete the application for the eligibility determination by mail or over the phone.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0060, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0070 Who can apply for an eligibility determination? (1) The following individuals can apply for a determination of developmental disability:

(a) The parent or legal representative must apply on behalf of a child under the age of eighteen years;

(b) If there is a legal guardian of an applicant age eighteen years or older, the legal guardian must apply on behalf of the adult applicant; or

(c) If there is no legal guardian of an adult applicant age eighteen years or older, the adult applicant can apply on his/her own behalf.

(2) Any person, agency, or advocate may refer an adult for a determination of a developmental disability and assist with the application process. However, since the request for a determination of developmental disability is voluntary, DDD will request the verbal or written consent from the legal guardian of the adult or from the adult applicant if there is no legal guardian.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0070, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0080 Who determines that I have a developmental disability? DDD determines if you have a developmental disability as defined in this chapter after reviewing all documentation received by the division.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0080, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0090 How long will it take to complete a determination of my eligibility? (1) Once DDD receives sufficient documentation to determine you eligible, DDD has thirty days from receipt of the final piece of documentation to make the determination of eligibility.

(2) If DDD has received all requested documentation but it is insufficient to establish eligibility, DDD will make a determination of ineligibility and send you written notice of denial of eligibility.

(3) If DDD has insufficient information to determine you eligible but has not received all of the requested documentation, DDD may deny your eligibility after ninety days from the date of application. Rules governing reapplying for eligibility are in WAC 388-823-1080.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0090, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0100 What is the effective date that I become an eligible client of DDD? (1) If DDD receives sufficient information to substantiate your DDD eligibility, the effective date of your eligibility as a DDD client is the date of receipt of the final piece of documentation.

(2) Paid DDD services cannot begin before the effective date of your DDD eligibility.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0100, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0105 How will DDD notify me of the results of my eligibility determination? DDD will send you written notification of the final determination of your eligibility per WAC 388-825-100.

(1) If you are not eligible, the written notice will explain why you are not eligible, explain your appeal rights to this decision, and provide you with a fair hearing request form.

(2) If you are eligible, the written notice will include:

(a) Your eligibility condition(s);

(b) The effective date of your eligibility;

(c) The expiration date or review date of your eligibility, if applicable; and

(d) The name and phone number of your assigned case manager.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0105, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0110 Who is responsible for obtaining the documentation needed to make this eligibility determination? You are responsible to obtain all of the information needed to document your disability or to provide DDD with the sources for obtaining the documentation.

(1) DDD will assist you in obtaining records but the purchase of diagnostic assessments or intelligence quotient (IQ) testing is your responsibility.

(2) If DDD determines that an Inventory of Client and Agency Planning (ICAP) is required, DDD will administer the ICAP at no expense to you.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0110, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0120 Will my diagnosis of a developmental disability qualify me for DDD eligibility? Eligibility for DDD requires more than a diagnosis of a developmen-

tal disability. You must meet all of the elements that define a developmental disability in WAC 388-823-0040 and meet the requirements of a specific eligible condition defined in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0120, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0130 Can I be eligible for DDD if my disability occurs on or after my eighteenth birthday? DDD eligibility requires that your disability exist before your eighteenth birthday.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0130, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0140 What if I do not have written evidence that my disability began before my eighteenth birthday? (1) If there is no documentation available to prove that your disability began prior to age eighteen, DDD may accept verbal information from your family or others who knew you prior to the age of eighteen about your early developmental history, educational history, illnesses, injuries or other information sufficient to validate the existence of an eligible condition prior to age eighteen.

(2) DDD will determine if the reported verbal information is adequate for documenting the existence of your condition prior to age eighteen.

(3) Additional evidence of your eligible condition and the resulting substantial limitations to adaptive functioning is still required.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0140, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0150 Which rules define a developmental disability if I am a child under the age of six years? If you are a child under the age of six years, assessment of developmental delays and other age appropriate criteria are used to substantiate an eligible condition and substantial limitations in adaptive functioning as defined in WAC 388-823-0800 through 388-823-0850.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0150, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0160 Which rules define a developmental disability if I am age six through nine? If you are a child age six but under age ten, you can meet the criteria for a developmental disability under either of the two following sets of rules:

(1) Developmental delays per WAC 388-823-0800 through 388-823-0850; or

(2) Developmental disabilities per WAC 388-823-0200 through 388-823-0710.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0160, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0170 Which rules define a developmental disability if I am age ten or older? If you are age ten or older, only the rules in WAC 388-823-0200 through 388-823-0710 apply when deciding if you have a developmental disability.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0170, filed 6/1/05, effective 7/2/05.]

DETERMINATION OF A DEVELOPMENTAL DISABILITY MENTAL RETARDATION

WAC 388-823-0200 What evidence do I need to substantiate "mental retardation" as an eligible condition? Evidence that you have an eligible condition under "mental retardation" requires a diagnosis of mental retardation by a licensed psychologist, or a finding of mental retardation by a certified school psychologist or a diagnosis of Down syndrome by a licensed physician.

(1) This diagnosis is based on documentation of a lifelong condition originating before age eighteen.

(2) The condition results in significantly below average intellectual and adaptive skills functioning that will not improve with treatment, instruction or skill acquisition.

(3) A diagnosis or finding of mental retardation by the examining psychologist must include an evaluation of adaptive functioning that includes the use of a standardized adaptive behavior scale indicating adaptive functioning that is more than two standard deviations below the mean, in at least two of the following areas: Communication, self care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health, and safety.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0200, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0210 If I have mental retardation, how do I meet the definition of substantial limitations in adaptive functioning? (1) If you meet the definition of mental retardation in WAC 388-823-0200, you must have substantial limitations in adaptive functioning of two standard deviations below the mean and a full-scale intelligence quotient (FSIQ) of more than two standard deviations below the mean.

(2) The substantial limitation in adaptive functioning must reflect your current condition.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0210, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0215 What evidence do I need of my FSIQ? Evidence of a qualifying FSIQ to meet the definition of substantial limitations for the condition of mental retardation is a FSIQ derived from a Stanford-Binet, Wechsler intel-

ligence scale (Wechsler), differential abilities scale (DAS), Kaufman assessment battery for children (K-ABC), or a Leiter international performance scale-revised (Leiter-R) if you have a significant hearing impairment or English is not your primary language.

(1) The test must be administered by a licensed psychologist or certified school psychologist.

(2) The FSIQ cannot be attributable to mental illness or other psychiatric condition occurring at any age; or other illness or injury occurring after age eighteen:

(a) If you are dually diagnosed with mental retardation and mental illness, other psychiatric condition, or other illness or injury, DDD must make its eligibility decision based solely on the diagnosis of mental retardation, excluding the effects of the mental illness, other psychiatric condition, illness or injury; or

(b) If DDD is unable to make this eligibility decision based solely on the diagnosis of mental retardation due to the existence of mental illness, other psychiatric condition or illness or injury, DDD will deny eligibility.

(3) If you have a significant hearing impairment, the administering professional may estimate an FSIQ score using only the performance IQ score of the appropriate Wechsler or administer the Leiter-R.

(4) If you have a vision impairment that prevents completion of the performance portion of the IQ test, the administering professional may estimate an FSIQ using only the verbal IQ score of the appropriate Wechsler.

(5) The following table shows the standard deviation for each assessment and the qualifying score of more than two standard deviations below the mean.

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Stanford-Binet 4th edition	16	67 or less
Stanford-Binet 5th edition	15	69 or less
Wechsler Intelligence Scales (Wechsler)	15	69 or less
Differential Abilities Scale (DAS)	15	69 or less
Kaufman Assessment Battery for Children (K-ABC)	15	69 or less
Leiter International Performance Scale-Revised (Leiter-R) [for persons with significant hearing impairments or when English is not a primary language]	15	69 or less

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0215, filed 6/1/05, effective 7/2/05.]

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 388-823-0220 If I am too intellectually impaired to complete a standardized IQ test, how do I meet the criteria under mental retardation? If in the opinion of the examining psychologist, you are too intellectually impaired to complete all of the subtests necessary to achieve an FSIQ score on an approved standardized IQ test, the examining psychologist may estimate an FSIQ from the available information based on a professional judgment about your intellectual functioning.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0220, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0230 If I have more than one FSIQ score, what criteria will DDD use to select the FSIQ score for determining eligibility? (1) If you have more than one FSIQ, DDD will review the pattern of FSIQ scores.

(a) If there is no significant difference among these, DDD will accept the score the closest to age eighteen.

(b) If there are significant differences among the FSIQ scores, DDD will review the pattern and attempt to determine reasons for the fluctuations to ensure that the FSIQ is resulting from mental retardation and not from mental illness or other psychiatric condition, or illness, or other injury.

(i) If you are age eighteen or older, DDD will use the FSIQ obtained at age thirteen or older, provided the FSIQ is resulting from mental retardation.

(ii) If you are under age eighteen, DDD will use the most current FSIQ, provided the FSIQ is resulting from mental retardation.

(2) DDD will exclude any FSIQ score attributable to a condition or impairment that began on or after your eighteenth birthday.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0230, filed 6/1/05, effective 7/2/05.]

CEREBRAL PALSY

WAC 388-823-0300 What evidence do I need to substantiate "cerebral palsy" as an eligible condition? Evidence that you have an eligible condition under "cerebral palsy" requires a diagnosis by a licensed physician of cerebral palsy, quadriplegia, hemiplegia, or diplegia with symptoms that:

(1) Existed prior to age three; and

(2) Impair control of movement.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0300, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0310 If I have cerebral palsy, how do I meet the definition of substantial limitations to adaptive functioning? If you have an eligible condition of cerebral

palsy, substantial limitations of adaptive functioning is the need for direct physical assistance on a daily basis with two or more of the following activities as a result of your condition:

(1) Toileting;
(2) Bathing;
(3) Eating;
(4) Dressing;
(5) Mobility; or
(6) Communication.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0310, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0320 What evidence do I need of my need for direct physical assistance with activities of daily living? Evidence for direct physical assistance with activities of daily living means:

(1) You need the presence and assistance of another person on a daily basis to be able to communicate and be understood by any other person.

(a) If you are able to communicate through a communication device you will be considered independent in communication.

(b) You must require more than "setting up" of the communication device.

(2) You need direct physical assistance from another person on a daily basis with toileting, bathing, eating, dressing, or mobility.

(a) You require more than "setting up" the task to enable you to perform the task independently.

(b) You must require direct physical assistance for more than transferring in and out of wheelchair, in and out of the bath or shower, and/or on and off of the toilet.

(c) Your ability to be mobile is your ability to move yourself from place to place, not your ability to walk. For instance, if you can transfer in and out of a wheelchair and are independently mobile in a wheelchair, you do not meet the requirement for direct physical assistance with mobility.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0320, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0330 How can I document my need for direct physical assistance? Any of the following can be used as evidence to determine your direct physical assistance needs:

(1) The comprehensive assessment reporting evaluation (CARE) tool or other department assessments that measure direct assistance needs in the areas specified above;

(2) Assessments and reports from educational or healthcare professionals that are current and consistent with your current functioning;

(3) In the absence of professional reports or assessments, DDD may document its own observation of your direct assistance needs along with reported information by family and others familiar with you.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0330, filed 6/1/05, effective 7/2/05.]

EPILEPSY

WAC 388-823-0400 What evidence do I need to substantiate "epilepsy" as an eligible condition? Evidence of an eligible condition under "epilepsy" requires a diagnosis of a neurological condition that produces brief disturbances in the normal electrical functions of the brain resulting in seizures.

(1) This condition requires a diagnosis of epilepsy or seizure disorder that originated prior to age eighteen and is expected to continue indefinitely.

(2) The diagnosis must be made by a board certified neurologist and be based on documentation of medical history and neurological testing.

(3) You must provide confirmation from your physician or neurologist that your seizures are currently uncontrolled and ongoing or recurring and cannot be controlled by medication.

(4) DDD will not consider your seizures uncontrolled or ongoing if it is documented or reported that you refuse to take medications.

(5) Your seizures must make you physically incapacitated, requiring direct physical assistance for one or more activities as defined in WAC 388-823-0310 and 388-823-0320 during or following seizures.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0400, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0410 If I have epilepsy, how do I meet the definition of substantial limitations to adaptive functioning? A substantial limitation to adaptive functioning under epilepsy is a functional assessment score of more than two standard deviations below the mean on a Vineland adaptive behavior scales (VABS), scale of independent behavior-revised (SIB-R) or inventory for client and agency planning (ICAP) assessment instrument as described in WAC 388-823-0420.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0410, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0420 What evidence do I need to substantiate adaptive functioning limitations for the eligible conditions of epilepsy, autism and other conditions similar to mental retardation? (1) Evidence of substantial limitations of adaptive functioning for the conditions of epilepsy, autism, and other conditions similar to mental retardation requires a qualifying score completed in the past thirty-six months in a VABS or a SIB-R, or a qualifying score completed in the past twenty-four months in an ICAP.

(a) Professionals who administer and score the VABS must have a background in individual assessment, human development and behavior, and tests and measurements, as well as an understanding of individuals with disabilities.

(b) Department staff or designee contracted with DDD must administer the ICAP.

(c) DDD will administer or arrange for the administration of the ICAP if VABS or SIB-R results are not submitted.

(d) Qualifying scores for each assessment are as follows:

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Vineland Adaptive Behavior Scales (VABS)	15	An adaptive behavior composite score of 69 or less
Scales of Independent Behavior-Revised (SIB-R)	15	A broad independence standard score of 69 or less for the adaptive behaviors
Inventory for Client and Agency Planning (ICAP)	15	Pursuant to WAC 388-823-0900, the broad independence domain score based on the applicant's birth date and the date the test is administered.

(2) If DDD is unable to determine that your current adaptive functioning impairment is the result of your developmental disability because you have an unrelated injury or illness that is impairing your current adaptive functioning:

(a) DDD will not accept the results of a VABS or SIB-R administered after that event and will not administer the ICAP; and

(b) Your eligibility will have to be determined under a different condition that does not require evidence of adaptive functioning per a VABS, SIB-R or ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0420, filed 6/1/05, effective 7/2/05.]

AUTISM

WAC 388-823-0500 What evidence do I need to substantiate "autism" as an eligible condition? Evidence of an eligible condition under "autism" requires a diagnosis by a qualified professional of autism or autistic disorder per 299.00 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) that is expected to continue indefinitely, and evidence of onset before age three.

(1) The following professionals are qualified to give this diagnosis:

(a) Board eligible neurologist;

(b) Board eligible psychiatrist;

(c) Licensed psychologist; or

(d) Board certified developmental and behavioral pediatrician.

(2) The evidence provided by a diagnosing professional in subsection (1) above exhibits a total of six or more of the following diagnostic criteria listed in the current DSM-IV-TR for Autistic Disorder 299.00:

(a) Two or more qualitative impairments in social interactions;

(b) One or more qualitative impairments in communication; and

(c) One or more impairments in restricted repetitive and stereotypical patterns or behavior, interests, and activities.

(3) A checklist of diagnostic criteria follows:

DSM-IV-TR Diagnostic Criteria required for Autism	Check if present
1. Qualitative impairment in social interaction	
a. Marked impairment in the use of multiple nonverbal behaviors	
b. Failure to develop peer relationships appropriate to developmental level	
c. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people	
d. Lack of social or emotional reciprocity	
2. Qualitative impairment in communication	
a. Delay in the development of spoken language without nonverbal compensation	
b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others	
c. Stereotyped and repetitive use of language or idiosyncratic use of language	
d. Lack of varied, spontaneous, make-believe play or social imitative play appropriate to developmental level	
3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities	
a. Encompassing preoccupation with stereotyped and restricted patterns of interest that is abnormal in either intensity or focus	
b. Apparently inflexible adherence to specific, nonfunctional routines or rituals	
c. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)	
d. Persistent occupation with parts of objects	
TOTAL	

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0500, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0510 If I have autism, how do I meet the definition of substantial limitations to adaptive functioning? A substantial limitation of adaptive functioning for the condition of autism is the presence of adaptive functioning impairment as described in WAC 388-823-0515.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0510, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0515 What evidence do I need to substantiate adaptive functioning limitations for the condition of autism? Evidence of the substantial limitations of adaptive functioning for the condition of autism is both (1) and (2) below:

(1) Evidence of delay or abnormal functioning prior to age three years in at least one of the following areas:

(a) Social interaction;

(b) Language as used in social interaction;

(c) Communication; or

(d) Symbolic or imaginative play.

(2) Eligible scores in adaptive functioning per WAC 388-823-0420 (1)(d) and subject to all of WAC 388-823-0420.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0515, filed 6/1/05, effective 7/2/05.]

ANOTHER NEUROLOGICAL CONDITION

WAC 388-823-0600 What evidence do I need to substantiate "another neurological condition" as an eligible condition? Evidence of an eligible condition under "another neurological condition" requires a diagnosis by a licensed physician of an impairment of the central nervous system involving the brain and/or spinal cord that meets all of the following:

(1) Originated before age eighteen;

(2) Results in both physical disability and intellectual impairment;

(3) Is expected to continue indefinitely; and

(4) Is not attributable to a mental illness or psychiatric disorder.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0600, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0610 If I have another neurological condition, how do I meet the definition of substantial limitations to adaptive functioning? Substantial limitations to adaptive functioning for the condition of another neurological condition require both intellectual impairment and the need for direct physical assistance with activities of daily living per WAC 388-823-0615 (1) and (2) below.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0610, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0615 What evidence do I need to substantiate adaptive functioning limitations for another neurological condition? Evidence of substantial limitations to intellectual functioning for another neurological condition is all of the following:

(1) You must have an FSIQ score of 1.5 or more standard deviations below the mean on one of the following acceptable assessments in addition to the other criteria in this section. The acceptable assessments, the standard deviation and the qualifying scores are contained in the following table:

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Stanford-Binet 4th edition	16	76 or less
Stanford-Binet 5th edition	15	78 or less
Wechsler	15	78 or less
Differential Abilities Scale (DAS)	15	78 or less
Kaufman Assessment Battery for Children (K-ABC)	15	78 or less
Leiter-R [for persons with significant hearing impairments or when English is not primary language]	15	78 or less

(2) You must have evidence of need for direct physical assistance on a daily basis with two or more of the following activities: Toileting, bathing, eating, dressing, mobility, or communication as a result of your condition as defined in WAC 388-823-0320 and 388-823-0330.

(3) The intellectual impairment and physical assistance needs must be the result of the central nervous system impairment and not due to another condition or diagnosis.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0615, filed 6/1/05, effective 7/2/05.]

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.

"OTHER CONDITION" SIMILAR TO MENTAL RETARDATION

WAC 388-823-0700 How do I meet the definition for an "other condition" similar to mental retardation? You will need evidence in (1) or (2) below to substantiate that you have an "other condition" similar to mental retardation.

(1) You have a diagnosis of a condition or disorder that by definition results in both intellectual and adaptive skills deficits; and

(a) The diagnosis must be made by a licensed physician or licensed psychologist;

(b) The diagnosis must be due to a neurological condition, central nervous system disorder involving the brain or spinal column, or chromosomal disorder;

(c) The diagnosis or condition is not attributable to or is itself a mental illness, or emotional, social or behavior disorder;

(d) The condition must have originated before age eighteen; and

(e) The condition must be expected to continue indefinitely.

(2) You are under the age of eighteen and are eligible for DSHS-paid in-home nursing through the medically intensive program, defined in WAC 388-551-3000.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0700, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0710 What evidence do I need to meet the definition of substantial limitations for an "other condition" similar to mental retardation? (1) Evidence of substantial limitation in both (a) and (b) below is required for an "other condition" similar to mental retardation.

(a) Evidence of intellectual impairment requires documentation of either (i) or (ii) or (iii) below:

(i) An FSIQ of 1.5 or more standard deviations below the mean as described in WAC 388-823-0615(1) for another neurological condition; or

(ii) Significant academic delays resulting in delay of at least twenty-five percent below the chronological age or age equivalent academic functioning in at least two academic areas or grade placement; or

(iii) In the absence of school records to substantiate (ii) above, DDD may review other information about your academic progress sufficient to validate your cognitive deficits.

(b) Unless there is evidence of other conditions or impairments unrelated to the eligible condition currently affecting adaptive functioning, the following evidence will determine if the eligible condition or disorder results in a substantial limitation in adaptive functioning:

(i) A score of more than two standard deviations below the mean on a VABS or SIB-R current within the past three years, or in the absence of a VABS or SIB-R, an ICAP administered by DDD within the past twenty-four months.

(ii) The qualifying scores for these tests are listed in WAC 388-823-0420 (1)(d).

(2) You do not need the additional evidence of your substantial limitations to adaptive functioning in (1)(a) and (b) above if your eligible condition is solely due to your eligibility and participation in the medically intensive program offered through DDD, defined in WAC 388-551-3000.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0710, filed 6/1/05, effective 7/2/05.]

EFFECT OF AGE ON ELIGIBILITY

WAC 388-823-0800 Which eligible developmental disability conditions apply at what age? (1) Children under the age of six must meet the definition of having a developmental disability by meeting the requirements listed in WAC 388-823-0810 through 388-823-0850.

(2) Children at least age six but under the age of ten can meet the definition of developmental disability by:

(a) Meeting the requirements listed in WAC 388-823-0200 through 388-823-0710; or

(b) Meeting the requirements listed in WAC 388-823-0810 through 388-823-0850.

(3) Children age ten and older must meet the requirements in WAC 388-823-0200 through 388-823-0710.

(4) The following chart summarizes the applicable eligibility conditions by age.

Eligible Conditions	Age 0-5	Age 6-9	Age 10-17	Age 18 and older
Developmental Delays	X	X		
Down Syndrome	X	X		
Too severe to be assessed	X	X		
Medically Intensive	X	X	X	
Mental Retardation (MR)		X	X	X
Cerebral Palsy		X	X	X
Epilepsy		X	X	X
Autism		X	X	X
Another Neurological		X	X	X
Other condition similar to MR		X	X	X

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0800, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0810 If I am a child under age ten, what evidence do I need to meet the definition for an "other condition" similar to mental retardation? If you are a child under age ten, evidence of one of the following substantiates that you have an eligible "other condition" similar to mental retardation:

(1) Developmental delay measured by developmental assessment tools administered by qualified professionals as described in WAC 388-823-0850.

(2) A diagnosis of Down syndrome by a licensed physician;

(3) A determination of eligibility for the DSHS medically intensive program;

(4) A diagnosis by a licensed physician or licensed psychologist of a condition that is so severe the child is unable to demonstrate the minimal skills required to complete a developmental evaluation or assessment.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0810, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0820 If I am a child under age ten with an eligible condition under the medically intensive program, Down syndrome, or a diagnosed condition that is too severe for developmental testing, how do I meet the definition of substantial limitations to adaptive functioning? You do not need additional evidence of substantial limitations if you are a child under the age of ten with an eligible condition based on the medically intensive program, Down syndrome, or a diagnosed condition that is too severe for developmental testing.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0820, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0830 If I am a child under age ten with an eligible condition based on developmental delays, how do I meet the definition of substantial limitations to adaptive functioning? (1) If you are a child under age ten with an eligible condition based on developmental delays, evidence of substantial handicap requires developmental delays of at least 1.5 standard deviations or twenty-five percent or more of the chronological age in the following developmental areas:

(a) Physical skills (fine or gross motor);

(b) Self help/adaptive skills;

(c) Expressive or receptive communication, including American Sign Language;

(d) Social/emotional skills; and

(e) Cognitive, academic, or problem solving skills.

(2) The number of areas in which you are required to have delays to meet the evidence is specific to your age.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0830, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0840 If I am a child under age ten, how many areas of developmental delays meet the definition of substantial limitations to adaptive functioning? If you are a child under the age ten, eligible based on developmental delays, the number of delays required for substantial limitations to adaptive functioning is specific to your age.

(1) A child from birth but under age three must have a developmental delay in one or more developmental areas.

(2) A child age three but under age ten must have developmental delays in three or more developmental areas.

AGE	NUMBER of AREAS of DELAY
Birth but under age three	One or more
Age three but under age ten	Three or more

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0840, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0850 What developmental evaluations or assessments will be acceptable for determining developmental delay? DDD will accept any standardized developmental evaluation test of procedures to assess developmental delays if:

(1) The results of the evaluation/assessment are reasonably reliable and valid by professional standards.

(a) If you are under age three, there is an evaluation of developmental areas that is current within the past twelve months. Evaluations determine eligibility for services and need to address each of the five developmental areas.

(b) If you are age three or older, there is an assessment of developmental areas. Assessments are more detailed than evaluations and are needed for determining types of services, method, intensity, and funding. Assessments are also the way to document the ongoing status of child's development, progress and recommended steps to meet outcomes.

(2) The evaluation/assessment is administered by one of the following professionals qualified to administer the evaluation or assessment of developmental areas:

(a) Licensed physician;

(b) Licensed psychologist or certified school psychologist;

(c) Speech language pathologist;

(d) Audiologist;

(e) Registered occupational therapist;

(f) Licensed physical therapist;

(g) Registered nurse;

(h) Certified teacher;

(i) Masters level social worker; or

(j) Orientation and mobility specialist.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0850, filed 6/1/05, effective 7/2/05.]

INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)

WAC 388-823-0900 What are the qualifying scores for inventory of client and agency planning broad independence for each age? When the ICAP is administered to determine eligibility under substantial handicap for a developmental disability, the qualifying score must be at or below the three digit broad independence domain score specific to the age of the applicant at the time of the administration of the ICAP. The score specific to age follows:

AGE	SCORE (at or below)
6	449
7	456
8	463
9	469
10	476
11	482
12	487
13	492
14	497
15	501
16	505
17 and older	509

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0900, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0910 What is the purpose of ICAP? The purpose of the ICAP is to assess your adaptive skills in the areas of motor skills, personal living skills, social and communication skills, and community living skills.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0910, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0920 What sections of the ICAP does DDD or a designee contracted with DDD complete and score? (1) DDD or a designee contracted with DDD completes the adaptive behavior portion of the ICAP.

(2) There is a computer generated broad independence score of your motor skills, personal living skills, social and communication skills, and community living skills, based on your age.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0920, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0930 How does DDD or a designee contracted with DDD administer the ICAP? (1) DDD or a designee contracted with DDD completes the adaptive section of the ICAP by interviewing a qualified respondent who has known you for at least three months and who sees you on a day-to-day basis. You cannot be the respondent for your own ICAP.

(2) DDD or a designee contracted with DDD will choose the respondent and may interview more than one respondent to ensure that information is complete and accurate.

(3) DDD or a designee contracted with DDD will ask you to demonstrate some of the skills in order to evaluate what skills you are able to perform. DDD or a designee contracted with DDD cannot administer the ICAP if no respondent is identified and available.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0930, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0940 What happens if DDD or a designee contracted with DDD cannot identify a qualified respondent? If you and DDD or a designee contracted with DDD cannot identify a qualified respondent for the ICAP, DDD or a designee contracted with DDD will not be able to administer the ICAP or determine you eligible under any conditions that require an ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0940, filed 6/1/05, effective 7/2/05.]

ELIGIBILITY EXPIRATION, REVIEWS, AND REAPPLICATION

WAC 388-823-1000 Once I become an eligible DDD client, is there a time limit to my eligibility? While DDD has the authority to review your eligibility at any time, your eligibility as a DDD client will expire or have required reviews as indicated in WAC 388-823-1005 and 388-823-1010.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1000, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1005 When does my eligibility as a DDD client expire? (1) If you are determined eligible prior to age four, your eligibility expires on your fourth birthday.

(a) DDD will notify you at least ninety days before your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(2) If you are determined or redetermined eligible at age three but under age ten per WAC 388-823-0810 through 388-823-0850, your eligibility expires on your tenth birthday.

(a) DDD will notify you at least ninety days before your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(3) If your eligibility determination was prior to July 2005 under developmental delays, Down syndrome, or medically intensive program and you are age four or older as of June 30, 2005, your eligibility expires on your tenth birthday.

(a) DDD will notify you at least ninety days before of your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(4) If your eligibility determination was made after July 2005 and is solely due to your need for nursing through the medically intensive program, your eligibility expires when you are no longer eligible for the program but no later than your eighteenth birthday.

(a) DDD will notify you at least ninety days before your eighteenth birthday.

(b) You must reapply for eligibility with DDD.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1005, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1010 When will DDD review my eligibility to determine if I continue to have a developmental disability? (1) Your eligibility can be reviewed at any time if your eligibility effective date is prior to July 2005 and you are age ten or older and were eligible under a condition of developmental delay or Down syndrome.

(2) Your eligibility will be reviewed at age seventeen with termination occurring no sooner than your eighteenth birthday if your most current eligibility determination was at sixteen or younger under mental retardation, cerebral palsy, epilepsy, autism, another neurological condition, or other condition similar to mental retardation.

(3) DDD will review your eligibility prior to the initial authorization of any paid service from DDD when you are not currently receiving paid services and:

(a) You are age eighteen or older and your most current eligibility determination is more than twenty-four months old; or

(b) You are age four but under age eighteen and your eligibility was established under the eligible conditions of developmental delay or Down syndrome and your eligibility effective date is prior to July 2005.

(4) DDD will review your eligibility if DDD discovers:

(a) The evidence used to make your most recent eligibility determination completed in 1992 or later appears to be insufficient, in error, or fraudulent; or

(b) New diagnostic information becomes available that does not support your current eligibility and you are under the age of eighteen.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1010, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1015 What is the definition of "DDD paid services" in WAC 388-823-1010(3)? DDD paid services are defined by one or more of the following:

(1) Authorization of a paid service within the last ninety days as evidenced by a social services payment system (SSPS) authorization, a county authorization for day program

services, a waiver plan of care approving a DDD paid service, or residence in a SOLA, RHC, or IMR (authorization of a state supplementary payment through SSPS does not meet the definition of a DDD paid service);

(2) Authorization of family support services within the last twelve months.

(3) 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.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1015, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1020 Can DDD terminate my eligibility if I no longer am a resident of the state of Washington? DDD will terminate your eligibility if you lose residency in the state of Washington as defined in WAC 388-823-0050.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1020, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1030 How will I know that my eligibility is expiring or is due for review? If your eligibility has a required expiration or review date, DDD will send you prior written notification with reapplication or review information.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1030, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1040 What happens if I do not reapply for eligibility before my eligibility expiration date? (1) If you fail to reapply before your eligibility expires on your fourth or tenth birthday or if you reapply so near in time to your fourth or tenth birthday that DDD does not have sufficient time to make an eligibility determination by the date of expiration, DDD eligibility will expire and your DDD paid services will stop.

(a) If DDD determines you eligible after your eligibility expires, your eligibility and paid services will be reinstated on the date that DDD determines you eligible pursuant to WAC 388-823-0100.

(b) If DDD determines you eligible after your eligibility expires, your eligibility and paid services will not be retroactive to the expiration date.

(2) This expiration of eligibility takes effect even if DDD is unable to locate you to provide written notification that eligibility is expiring.

(3) There is no appeal right to an expired eligibility determination.

(4) Your appeal rights to the termination of services resulting from a review of your eligibility due to the expiration of your eligibility on your fourth or tenth birthday are in WAC 388-825-120 and 388-825-150(2).

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1040, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1050 What happens if I do not respond to a request for information to review my eligibility? If you do not provide DDD with the information required to review and redetermine your eligibility, DDD will terminate your eligibility and any DDD services you might be receiving.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1050, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1060 How will DDD notify me of its decision? DDD will notify you and your legal representative or one other responsible party in writing of its determination of eligibility, ineligibility, or expiration of eligibility per WAC 388-825-100.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1060, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1070 What are my appeal rights to a department decision that I do not have a developmental disability? Your appeal rights to a department decision that you are not eligible to be a DDD client because you do not have a developmental disability are limited to those described in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1070, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1080 If DDD decides that I do not have a developmental disability, how soon can I reapply for another decision? If DDD decides that you do not have a developmental disability as defined in this chapter, you may reapply only if:

(1) Your eligibility was terminated because DDD could not locate you and you have subsequently contacted DDD;

(2) Your eligibility was terminated because you lost residency in the state of Washington and you have reestablished residency;

(3) You have additional or new information relevant to the determination that DDD did not review for the previous determination of eligibility; or

(4) DDD denied or terminated your eligibility based solely on your ICAP score and it has been more than twenty-four months since your last ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1080, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1090 If I am already eligible, how do these new rules affect me? If you are an eligible DDD client on the effective date of these rules, you continue to be an eligible DDD client but you are subject to the expiration and required eligibility reviews per WAC 388-823-1000 through 388-823-1050.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1090, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1095 What are my rights as a DDD client? As a DDD client, you have the following rights:

(1) The right to be free from any kind of abuse or punishment (verbal, mental, physical, and/or sexual); or being sent to a place by yourself, if you do not choose to be alone;

(2) The right to appeal any decision by DDD that denies, reduces, or terminates your eligibility, your services or your choice of provider;

(3) The right to receive only those services you agree to;

(4) The right to meet with and talk privately with your friends and family;

(5) The right to personal privacy and confidentiality of your personal and other records;

(6) The right to choose activities, schedules, and health care that meet your needs;

(7) The right to be free from discrimination because of your race, color, creed, national origin, religion, age, disability, marital status, or sexual orientation;

(8) The right to set your own rules in your home and to know what rules your providers have when you are living in their house or working in their facility;

(9) The right to request information regarding services that may be available from DDD;

(10) The right to know what your doctor wants you to do or take and to help plan how that will happen;

(11) The right to be free from unnecessary medication, restraints and restrictions;

(12) The right to vote and help people get elected to office;

(13) The right to complain and not to have someone "get even";

(14) The right to have your provider listen to your concerns including those about the behavior of other people where you live;

(15) The right to receive help from an advocate;

(16) The right to manage your money or choose other persons to assist you;

(17) The right to be part of the community;

(18) The right to make choices about your life;

(19) The right to wear your clothes and hair the way you want;

(20) The right to work and be paid for the work you do; and

(21) The right to decide whether or not to participate in research after the research has been explained to you, and after you or your guardian gives written consent for you to participate in the research;

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1095, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1100 How do I complain to DDD about my services or treatment? If you have a complaint or grievance about your services or treatment, follow these steps in this order:

(1) First, contact your case resource manager or social worker by phone, in writing, e-mail, or in person and explain your problem.

(2) If you are not happy with the results from speaking with your case resource manager or social worker, you may ask to speak with their supervisor.

(3) If steps (1) and (2) do not solve your problem, you submit your complaint in writing to the regional office.

(4) If you do not reach a solution with the regional office, you can request that your complaint be forwarded to the DDD headquarters in Olympia.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1100, filed 6/1/05, effective 7/2/05.]

Chapter 388-825 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES RULES

(Formerly chapter 275-27 WAC)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-825-025 Exemptions. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-025, filed 7/25/02, effective 8/25/02. 99-19-104, recodified

as § 388-825-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-023, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-023, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-023, filed 8/9/91, effective 9/9/91.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-030 Eligibility for services. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-030, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020. 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.

388-825-035 Determination of eligibility. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-035, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.

388-825-040 Application for services. [99-19-104, recodified as § 388-825-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-040, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-040, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-040, filed 3/16/78; Order 1143, § 275-27-040, filed 8/11/76.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.

388-825-045 Determination for necessary services. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-045, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-050, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-050, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-050, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-050, filed 3/16/78; Order 1143, § 275-27-050, filed 8/11/76.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-050 Individual service plan. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-050, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-060, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-060, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-060, filed 3/16/78; Order 1143, § 275-27-060, filed 8/11/76.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-055 Authorization of services. [Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-825-055, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-055, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-055, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-230, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-230, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-230, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-230, filed 7/18/84. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-27-230, filed 3/1/82. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-230, filed 3/16/78; Order 1143, § 275-27-230, filed 8/11/76.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-060 What are the eligibility requirements for persons who receive funds directly for employment/day programs? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-060, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-064 What are the restrictions on the use of the funds paid directly to persons for employment/day programs? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-064, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-065 Financial services. [99-19-104, recodified as § 388-825-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-240, filed 7/18/84; Order 1143, § 275-27-240, filed 8/11/76.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-070 What happens if I do not spend the funds paid directly to me for employment/day programs as specified in WAC 388-825-064? [Statutory Authority: RCW 71A.12.030, 71A.10.020, and 2002 c 371. 04-11-087, § 388-825-070, filed 5/18/04, effective 6/18/04; 04-02-014, § 388-825-070, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-075 How much money will I receive? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-075, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-076 How often will I receive a direct payment check for my employment/day program services? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-076, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-077 Who will the warrant/check be sent to? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-077, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-078 How will the warrant/check be sent? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-078, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective

6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-080 Guardianship services. [99-19-104, recodified as § 388-825-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-250, filed 7/18/84; Order 1143, § 275-27-250, filed 8/11/76.] Repealed by 08-11-072, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW.

388-825-085 What is a representative payee? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-085, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-086 Who can be a representative payee for my DDD direct payment funds for employment/day program services? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-086, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-087 What are the responsibilities of a representative payee? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-087, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-090 When will DDD recover direct payment funds sent to me for employment/day program services? [Statutory Authority: RCW 71A.12.030, 71A.10.020, and 2002 c 371. 04-11-087, § 388-825-090, filed 5/18/04, effective 6/18/04; 04-02-014, § 388-825-090, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.-030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-095 Who is liable for repayment of an overpayment? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-095, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.-030, 71A.12.120, 71A.14.040, and Title 71A RCW.

388-825-170 Community alternatives program (CAP). [99-19-104, recodified as § 388-825-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-800, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-180 Eligible persons. [99-19-104, recodified as § 388-825-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-810, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-190 Community alternatives program (CAP)—Services. [99-19-104, recodified as § 388-825-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.-020. 91-17-005 (Order 3230), § 275-27-820, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-820, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-260 What are qualifications for individual service providers? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-260, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-262 What services do individuals provide for persons with developmental disabilities? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-262, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-264 If I want to provide services to persons with developmental disabilities, what do I do? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-264, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-266 If I want to provide respite care in my home, what is required? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-266, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-268 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? [Statutory Authority: RCW 71A.12.030 and 71A.12.-040. 99-23-021, § 388-825-268, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-270 Are there exceptions to the licensing requirement? [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-270, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-270, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-272 What are the minimum requirements to become an individual provider? [Statutory Authority: RCW 71A.12.-030 and 71A.12.040. 99-23-021, § 388-825-272, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-276 What are required skills and abilities for this job? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-276, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-278 Are there any educational requirements for individual providers? [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-278, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-278, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-280 What are the requirements for an individual supportive living service (also known as a companion home) contract? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-280, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-282 What is "abandonment of a vulnerable adult"? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-282, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

388-825-284 Are providers expected to report abuse? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-284, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.

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 388-825-020 Definitions. "Client or person" 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.

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

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities within the aging and disability services administration of the department of social and health services.

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse; natural, adoptive or step parents; grandparents; brother; sister; stepbrother; stepsister; uncle; aunt; first cousin; niece; or nephew.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide diagnosis, treatment and rehabilitation services to the mentally retarded or persons with related conditions.

"ICF/MR eligible" for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

(1) Twenty-four hour supervision; and

(2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"Individual support plan (ISP)" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Medicaid personal care" is the provision of medically necessary personal care tasks as defined in chapter 388-106 WAC.

"Residential habilitation center" or **"RHC"** means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

"Residential programs" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as licensed group homes, and nonfacility based, such as supported living and state-operated living alternatives (SOLA). Other residential programs include alternative living (as described in chapter 388-829A WAC, companion homes (as described in chapter 388-829C WAC), adult family homes, adult residential care services, children's foster homes, group care and staffed residential homes.

"Respite care" means short-term intermittent relief for persons normally providing care for the individuals.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"State supplementary payment (SSP)" is the state paid cash assistance program for certain DDD eligible SSI clients.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-020, filed 5/19/08, effective 6/19/08. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-020, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-020, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

WAC 388-825-056 What benefits do DDD paid services provide to me? DDD paid services provide one or more of the following benefits:

(1) An opportunity to learn, improve or retain social and adaptive skills necessary for living in the community;

(2) Health and safety;

(3) Personal power and choice;

(4) Competence and self reliance;

(5) Positive recognition by self and others;

(6) Positive relationships; and

(7) Integration into the physical and social life of the community.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-056, filed 5/19/08, effective 6/19/08.]

WAC 388-825-057 Am I eligible to receive paid services from DDD? You may be eligible to receive paid services from DDD if you are currently an eligible client of DDD per chapter 388-823 WAC and:

(1) You are under the age of three and meet the eligibility requirements contained in WAC 388-823-0800 through 388-823-0850; or

(2) You are a recipient of Washington state medicaid under the categorically needy program (CNP) and meet the eligibility requirements contained in chapters 388-474, 388-475 and 388-513 WAC; or

(3) You are enrolled in a DDD home and community based services waiver and meet the eligibility requirements contained in chapter 388-845 WAC; or

(4) You have been enrolled in the individual and family services program and meet the eligibility requirements contained in chapter 388-832 WAC; or

(5) You have been approved to receive a state-only funded service.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-057, filed 5/19/08, effective 6/19/08.]

WAC 388-825-0571 What services am I eligible to receive from DDD if I am under the age of eighteen, have been determined to meet DDD eligibility requirements, and I am in a dependency guardianship or foster care with children's administration? Your services from DDD are limited to medicaid personal care services and related case management if you meet the programmatic eligibility for medicaid personal care in chapter 388-106 and 388-71 WAC governing medicaid personal care (MPC) using the current department approved assessment form, comprehensive assessment reporting evaluation (CARE), and:

(1) You are under the age of eighteen;

(2) You have been determined to meet DDD eligibility requirements; and

(3) You are in a dependency guardianship or foster care with children's administration.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-0571, filed 5/19/08, effective 6/19/08.]

WAC 388-825-058 What services does DDD authorize? DDD authorizes:

(1) Medicaid state plan services;

(2) Infant toddler early intervention program (ITEIP) services;

(3) Home and community based services (HCBS) waiver services; and

(4) State-only funded services.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-058, filed 5/19/08, effective 6/19/08.]

WAC 388-825-059 How will I know which paid services I will receive? Your individual support plan (ISP) identifies the services and the amount of service you can receive.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-059, filed 5/19/08, effective 6/19/08.]

WAC 388-825-061 What service am I eligible for if I am under the age of three? (1) Children under age three are eligible for the infant toddler early intervention program (ITEIP) under the Individuals with Disabilities Education Act, (IDEA), Part C, and Washington's federally approved plan.

(2) Infants and toddlers eligible for DDD may receive DDD state-only funded child development services if funding is available.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-061, filed 5/19/08, effective 6/19/08.]

WAC 388-825-062 What is infant toddler early intervention program (ITEIP)? Infant toddler early intervention program (ITEIP) is a statewide, multi-agency program, administered by and located with DDD, to coordinate a system of early intervention services for children, birth to three, and their families under the Individuals with Disabilities Education Act (IDEA), Part C/ITEIP state rules and regulations.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-062, filed 5/19/08, effective 6/19/08.]

WAC 388-825-063 What services can infant toddler early intervention program (ITEIP) provide? Infant toddler early intervention program (ITEIP) provides family resources coordination (FRC) services. The FRC assists the family and child through the team evaluation/assessment process, eligibility determination. If eligible, the FRC coordinates the development of the individualized family service plan (IFSP) that documents outcomes, early intervention services, funding sources, supports and other information required for service delivery.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-063, filed 5/19/08, effective 6/19/08.]

WAC 388-825-066 Where do I find the program eligibility rules and service definitions for infant toddler early intervention program (ITEIP)? Eligibility for infant toddler early intervention program (ITEIP) is defined by the Individuals with Disabilities Education Act (IDEA), Part C, and Washington's federally approved plan. Additional ITEIP program and service information is on the ITEIP website: http://www1.dshs.wa.gov/iteip. You can locate the name of the family resources coordinator (FRC) online at http://www1.dshs.wa.gov/iteip/CountyOrgLinks.html or call the family health hotline at 1-800-322-2588. Parents may self-refer and do not need a doctor's referral for entry into early intervention.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-066, filed 5/19/08, effective 6/19/08.]

WAC 388-825-067 What are medicaid state plan services? (1) Medicaid state plan services are those services available to all persons eligible for medicaid under the categorically needy program. See WAC 388-475-0100 for the categorically needy program requirements.

(2) To receive the service, you must be assessed by DSHS to have an unmet need for the service and meet the eligibility criteria for the program. See WAC 388-825-068 for services authorized by DDD.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-067, filed 5/19/08, effective 6/19/08.]

WAC 388-825-068 What medicaid state plan services can DDD authorize? DDD can authorize the following medicaid state plan services:

(1) Medicaid personal care, per chapter 388-106 WAC;

(2) Private duty nursing for adults age eighteen and older; per chapter 388-106 WAC;

(3) Private duty nursing for children under the age of eighteen, per WAC 388-551-3000;

(4) Adult day health for adults, per WAC 388-106-0810 and 388-106-0815; and

(5) ICF/MR services, per chapters 388-835 and 388-837 WAC.

Medicaid State Plan Services	
Adult day health	Medicaid personal care
ICF/MR services	• In-home
Medically intensive home care program for children	• Adult family home
Private duty nursing for adults	• Adult residential care

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-068, filed 5/19/08, effective 6/19/08.]

WAC 388-825-069 What services are provided under a home and community based services (HCBS) waiver? (1) Home and community based services (HCBS) waivers provide specific services approved by the federal centers for medicare and medicaid services (CMS) under section 1915 (c) of the Social Security Act as an alternative to placement in an intermediate care facility for the mentally retarded (ICF/MR).

(2) Certain federal regulations governing ICF/MRs are "waived" enabling the provision of services in the home and community to persons who would otherwise require the services provided in an ICF/MR as defined in chapters 388-835 and 388-837 WAC.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-069, filed 5/19/08, effective 6/19/08.]

WAC 388-825-071 What services am I eligible for if I am enrolled in a DDD home and community based services (HCBS) waiver? If you are enrolled in a DDD home and community based services waiver, you are eligible for the services identified in your assessment and authorized in your individual support plan.

(1) Your waiver services are limited to the services available in your specific waiver based on an assessment of your health and welfare needs.

(2) The services available through each of DDD's HCBS waivers are described in chapter 388-845 WAC.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-071, filed 5/19/08, effective 6/19/08.]

WAC 388-825-072 Where do I find information on DDD's home and community based services (HCBS) waiver services, eligibility rules and definitions? Home and community based services (HCBS) waiver eligibility, the scope of services provided by each waiver, the definitions of the services, the limitations of the service, and qualified providers for the service are contained in chapter 388-845 WAC.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-072, filed 5/19/08, effective 6/19/08.]

WAC 388-825-073 What is a "state-only funded" service? State-only funded services are those services paid entirely with state funds. These services are limited by available funding.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-073, filed 5/19/08, effective 6/19/08.]

WAC 388-825-074 Am I eligible for state-only funded services? You are eligible to receive available state-only funded services if you have been approved for funding for that service, and all of the following conditions apply:

(1) You have a current DDD assessment that identifies the need for the service;

(2) You meet the programmatic and financial eligibility requirements for the specific service or program;

(3) Your need cannot be met through medicaid state plan services;

(4) You are not enrolled in a DDD home and community based services (HCBS) waiver;

(5) You do not receive SSP as a replacement for the requested service;

(6) The program or service is funded by the legislature.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-074, filed 5/19/08, effective 6/19/08.]

WAC 388-825-079 If I am not on a DDD HCBS waiver, can I receive services that are available through the DDD HCBS waivers with state-only funding? (1) With the exception of personal care, you may be authorized to receive any of the services that are available through the DDD HCBS waivers with state-only funding.

(2) Services that are available through the DDD HCBS waivers and authorized with state-only funding:

(a) Are subject to the definitions, limitations and provider qualifications contained in chapter 388-845 WAC; and

(b) Require prior approval by the director of DDD or designee.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-079, filed 5/19/08, effective 6/19/08.]

WAC 388-825-081 Can I receive state-only funded services that are not available in a DDD HCBS waiver? You may be authorized to receive state-only funded services that are available in other DSHS rules as defined below:

(1) Adult day care (WAC 388-106-0800);

(2) Attendant care (WAC 388-825-082);

(3) Childcare for foster children (chapter 388-826 WAC);

(4) Chore services (chapter 388-106 WAC);

(5) Supported living allowance (chapter 388-101 WAC);

(6) Individual and family assistance by the county (WAC 388-825-082);

(7) Information and education by the county (WAC 388-825-082);

(8) Medical and dental services (WAC 388-825-082);

(9) Psychological counseling (WAC 388-825-082);

(10) Reimbursement through a family support program to families for the purchase of approved items or service (WAC 388-825-242);

(11) State supplementary payments (chapter 388-827 WAC); and

(12) Transportation reimbursement for an escort (WAC 388-825-082).

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-081, filed 5/19/08, effective 6/19/08.]

WAC 388-825-082 What state-only funded services are authorized in DDD rules? The following state-only funded services defined below are authorized only by DDD and are not contained in other rules governing DDD.

(1) "Adult day care" not covered by medicaid is a DDD county service providing a structured social program for adults and is limited to persons receiving the service prior to June 2005.

(2) "Attendant care" provides respite care or personal care and is limited to persons who:

(a) Are not eligible for other DDD services to meet their need; and

(b) Were receiving attendant care in March 2004.

(3) "Individual and family assistance" is a time limited county service available to individuals and families.

(a) Supports are provided to additional families and persons with developmental disabilities in need of services within existing resources;

(b) Individuals and families receiving services have more control and flexibility with the use of the resources; and

(c) The individual and family are assisted in connecting to and using natural and informal community supports.

(4) "Information and education" is a county service that provides a variety of activities and strategies to assure that individuals with developmental disabilities and families have full access to current information about services and support that will assist them in becoming full participants in their communities.

(5) "Medical and dental services" means those services which are necessary for the health of the client and are not covered by medicaid or private insurance.

(6) "Psychological counseling" may provide specialized cognitive counseling, strategies for effectively relating to people or coping with situations and problems.

(7) "Transportation reimbursement for an escort" is the payment for someone other than the driver to provide one-on-one attention to the client being transported.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-082, filed 5/19/08, effective 6/19/08.]

WAC 388-825-083 Is there a comprehensive list of waiver and state-only DDD services? For medicaid state plan services authorized by DDD, see WAC 388-825-068. The following is a list of waiver and state-only services that DDD can authorize and those services that can be either a waiver or a state-only service:

(1) **Waiver personal care services that are not available with state-only funds include:**

(a) In-home services;

(b) Adult family home; and

(c) Adult residential care.

(2) **Waiver services that can be funded as state-only services:**

(a) Behavior management and consultation;

(b) Community transition;

(c) Environmental accessibility adaptations;

(d) Medical equipment and supplies;

(e) Occupational therapy;

(f) Physical therapy;

(g) Respite care;

(h) Sexual deviancy evaluation;

(i) Skilled nursing;

(j) Specialized medical equipment or supplies;

(k) Specialized psychiatric services;

(l) Speech, hearing and language therapy;

(m) Staff/family consultation and training;

(n) Transportation/mileage;

(o) Residential habilitation services (RHS), including:

(i) Alternative living;

(ii) Companion homes;

(iii) Supported living;

(iv) Group home;

(v) Child foster care;

(vi) Child group care;

(vii) Staffed residential; and

(viii) State operated SL;

(p) Employment/day programs, including:

(i) Community access;

(ii) Community guide;

(iii) Person-to-person;

(iv) Prevocational services; and

(v) Supported employment;

(q) ITEIP/County programs, including child development services;

(r) Mental health stabilization services, including:

(i) Behavior management and consultation;

(ii) Mental health crisis; and

(iii) Skilled nursing; and

(s) Specialized psychiatric services.

(3) **State-only services that are not available as a waiver service:**

(a) Adult day care;

(b) Architectural and vehicle modification;

(c) Attendant care;

(d) Child care for foster children;

(e) Chore services;

(f) Community services grant;

(g) Individual and family assistance;

(h) Information/education;

(i) Medical and dental services;

(j) Medical insurance copays and costs exceeding other coverage;

(k) Parent and sibling education;

(l) Parent training and counseling;

(m) Psychological counseling;

(n) Recreational opportunities;

(o) State supplementary payments;

(p) Specialized clothing;

(q) Specialized nutrition;

(r) Supported living;

(s) Training of the client;

(t) Transportation - cost of escort service or travel time; and

(u) Reimbursement to families for the purchase of approved items or services.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-083, filed 5/19/08, effective 6/19/08.]

WAC 388-825-084 What are the limitations of state-only funded services or programs? In addition to any limitations for state-only funded services or programs that are contained in the program specific rules, the following limitations apply to state-only funded services and programs.

(1) All state-only funded services are limited by available funding.

(2) The following programs are closed to new admissions:

(a) Adult day care; and

(b) Attendant care.

(3) Chore services are limited to persons who were receiving the service in 1998 and who have continued to receive this service monthly.

(4) Traditional family support (TFS) is limited to persons enrolled in the program as of May 31, 1996. This program ends on June 30, 2008.

(5) Family support opportunity (FSO) is limited to persons enrolled in the program from June 1, 1996 through March 27, 2006. This program ends on June 30, 2008.

(6) Family support pilot (FSP) is limited to persons enrolled in the program March 28, 2006 or later. This program ends on June 30, 2008.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-084, filed 5/19/08, effective 6/19/08.]

WAC 388-825-0871 Does DDD provide out-of-home residential services that address the special needs of persons with developmental disabilities? DDD provides the following out-of-home residential services that address the special needs of adults and children with developmental disabilities:

(1) Contracted and DDD-certified community based residential services for adults;

(2) Contracted community based services for children; and

(3) Residential habilitation centers (RHC) for a person of any age who requires ICF/MR or nursing facility care.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-0871, filed 5/19/08, effective 6/19/08.]

WAC 388-825-088 Where can I find more information about DDD contracted residential services? The information about DDD contracted residential services is in the following rules:

(1) Certified community residential services and supports are contained in chapter 388-101 WAC and include information regarding:

(a) Group homes (GH);

(b) Group training home;

(c) Supported living (SL); and

(d) State operated living alternative (SOLA).

(2) Alternative living services are contained in chapter 388-829A WAC;

(3) Companion home services are contained in chapter 388-829C WAC;

(4) Voluntary placement program services for children are contained in chapter 388-826 WAC and include information regarding:

(a) Foster homes;

(b) Group homes;

(c) Group training homes;

(d) Child placing agencies; and

(e) Staffed residential homes.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-088, filed 5/19/08, effective 6/19/08.]

WAC 388-825-089 What is a residential habilitation center (RHC)? A residential habilitation center or RHC is a state-only facility certified to provide ICF/MR services (see chapter 388-837 WAC) and/or nursing facility services (chapter 388-97 WAC) for persons who are eligible clients of DDD. RHCs include:

(1) Rainier School in Buckley, Washington;

(2) Francis Hadden Morgan Center in Bremerton, Washington;

(3) Fircrest School in Shoreline, Washington;

(4) Yakima Valley School in Selah, Washington; and

(5) Lakeland Village in Medical Lake, Washington.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-089, filed 5/19/08, effective 6/19/08.]

WAC 388-825-091 Am I eligible for residential habilitation center (RHC) services? You are eligible to receive residential habilitation center (RHC) services if:

(1) You are currently DDD eligible;

(2) You choose to receive services in the RHC;

(3) You need the level of care provided at the RHC; and

(4) DDD has determined that you can be supported safely in an RHC environment and will not pose a danger to other residents of the RHC.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-091, filed 5/19/08, effective 6/19/08.]

WAC 388-825-093 Can I receive a short term stay at a residential habilitation center (RHC)? If there is capacity at a residential habilitation center (RHC), the vacancies may be available for short term stays.

(1) Short term stays are limited by available vacancies;

(2) Short term stays must be included in your individual support plan; and

(3) Short term stays in excess of thirty days in a calendar year require approval by the director of the division of developmental disabilities.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-093, filed 5/19/08, effective 6/19/08.]

WAC 388-825-094 Can I request to live in an RHC? You may request admission to an RHC at any time.

(1) Your case/resource manager will update your DDD assessment and gather other information.

(2) Admission to an RHC requires approval by the director of the division of developmental disabilities or designee.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-094, filed 5/19/08, effective 6/19/08.]

WAC 388-825-096 Will I have to pay for the services DDD authorizes for me? (1) If you live in your own home, you do not pay toward the cost of your services except chore services. You must pay toward the cost of chore services as described in WAC 388-106-0625.

(2) If DDD authorizes you to live in a licensed community residential facility you must pay your room and board costs from your earned and unearned income. You may also be responsible for a portion of the cost of your care.

(a) If you are eligible for and receiving SSI or have SSI related eligibility per WAC 388-475-0100 (2)(a) or (b), you are not required to pay toward the cost of your care if you are living at home or in a community setting.

(b) If you are enrolled in a DDD HCBS waiver you must pay toward the cost of your services as described in WAC 388-515-1510.

(c) If you are not enrolled in a DDD HCBS waiver you must pay toward the cost of your services as described in WAC 388-106-0225.

(3) If you live in a medical institution you must pay toward the cost of your care as described in WAC 388-513-1380. See WAC 388-500-0005 for the definition of a medical institution.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-096, filed 5/19/08, effective 6/19/08.]

WAC 388-825-097 Are any of my expenses deducted from the income available to pay for my care in a licensed facility? After you pay for your room and board costs, some expenses may be deducted from the income available to pay for the cost of your care.

(1) If you have SSI related eligibility the cost of your payee or guardianship service may be deducted as described in chapter 388-79 WAC and WAC 388-475-0800(5).

(2) If you are enrolled in a DDD HCBS waiver refer to WAC 388-515-1510 for rules used to determine allowable deductions.

(3) If you are not enrolled in a DDD HCBS waiver refer to WAC 388-106-0225 for rules used to determine allowable deductions.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-097, filed 5/19/08, effective 6/19/08.]

WAC 388-825-098 Does DDD provide guardianship services? If it appears that you require a guardian to make legal, medical, and/or services decisions and to exercise your appeal rights to department decisions, the division's field services may request that an assistant attorney general initiate and/or assist in guardianship proceedings. The state does not pay the cost of guardianship fees.

[Statutory Authority: RCW 71A.10.015, 71A.12.020, 71A.12.030, and Title 71A RCW. 08-11-072, § 388-825-098, filed 5/19/08, effective 6/19/08.]

WAC 388-825-100 How will I be notified of decisions made by DDD? (1) Whenever possible, DDD will notify all parties affected by the decision by phone or in person.

(2) If you are under the age of eighteen, written notifications will be mailed to:

(a) You; and

(b) Your parent; or

(c) Your guardian or other legal representative.

(3) If you are age eighteen or older, written notifications will be mailed to you and:

(a) Your guardian or other legal representative; or

(b) A person identified by you to receive these notices in addition to yourself if you do not have a guardian or legal representative. Unless the person identified by you is a relative of yours, he or she cannot be an employee of DDD, a contractor with DDD or an employee of a contractor with DDD.

[Statutory Authority: RCW 71.10.060, 71A.12.030, and Title 71A RCW. 08-16-122, § 388-825-100, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-100, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.-030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-100, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-100, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

WAC 388-825-101 Why does DDD need to send my notices and correspondence to someone else? DDD sends your notices and correspondence to someone else to assist you to understand the information and your appeal rights to department decisions.

[Statutory Authority: RCW 71.10.060, 71A.12.030, and Title 71A RCW. 08-16-122, § 388-825-101, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-101, filed 7/16/04, effective 8/16/04.]

WAC 388-825-102 What if I do not want my DDD notices and correspondence sent to anyone else? (1) If you are age eighteen or older and do not have a legal guardian, you may request in writing that your DDD notices and correspondence be given only to you.

(2) DDD will review your request and comply with your request unless it determines there to be a risk of your losing rights.

(3) You have the right to appeal a denial of this request.

[Statutory Authority: RCW 71.10.060, 71A.12.030, and Title 71A RCW. 08-16-122, § 388-825-102, filed 8/5/08, effective 9/5/08. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-102, filed 7/16/04, effective 8/16/04.]

WAC 388-825-103 When will I receive written notice of decisions made by DDD? You will receive written notice from DDD of the following decisions:

(1) The denial or termination of eligibility for services under WAC 388-825-030 and 388-825-035;

(2) The authorization, denial, reduction, or termination of services or the payment of SSP set forth in chapter 388-827 WAC that are authorized by DDD;

(3) The admission or readmission to, or discharge from a residential habilitation center.

(4) Disenrollment from a DDD home and community based services waiver under WAC 388-845-0060, including a disenrollment from a waiver and enrollment in a different waiver.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 08-04-072, § 388-825-103, filed 2/4/08, effective 3/6/08. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-825-103, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-103, filed 7/16/04, effective 8/16/04.]

WAC 388-825-104 What information will the notice include? The notice from DDD will include:

(1) The decision;

(2) The reason for the decision;

(3) The effective date of the action;

(4) Appeal rights to the decision; and

(5) The name and phone number of a department person you can contact for further information.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-104, filed 7/16/04, effective 8/16/04.]

WAC 388-825-105 Am I given any advance notice of termination or reduction or eligibility or services? (1) DDD will provide you at least ten-days advance notice, as described in WAC 388-458-0040 (1), (2) and (3), of any action to terminate your eligibility, or terminate or reduce your services.

(2) DDD will provide you at least thirty-days advance notice prior to transferring you from a residential habilitation center to the community under RCW 71A.20.080.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-105, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-105, filed 7/16/04, effective 8/16/04.]

WAC 388-825-120 When can I appeal department decisions through an administrative hearing process? (1) Administrative hearings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter and by chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC or

WAC 388-440-0001(3), the provision in this chapter shall prevail.

(2) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an administrative hearing.

(3) You have the right to an administrative hearing to dispute the following department actions:

(a) Authorization, denial, reduction, or termination of services;

(b) Reduction or termination of a service that was initially approved through an exception to rule;

(c) Authorization, denial, or termination of eligibility;

(d) Authorization, denial, reduction, or termination of payment of SSP authorized by DDD set forth in chapter 388-827 WAC;

(e) Admission or readmission to, or discharge from, a residential habilitation center;

(f) Refusal to abide by your request not to send notices to any other person;

(g) Refusal to comply with your request to consult only with you;

(h) A decision to move you to a different type of residential service;

(i) Denial or termination of the provider of your choice or the denial of payment for any reason listed in WAC 388-825-375 through 388-825-390;

(j) An unreasonable delay to act on an application for eligibility or service;

(k) A claim the client, former client, or applicant owes an overpayment debt.

[Statutory Authority: RCW 71A.12.030. 06-19-037, § 388-825-120, filed 9/13/06, effective 10/14/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-120, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-120, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-120, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, 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), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

WAC 388-825-125 How do I request an administrative hearing? (1) Your notice of the department decision will include instructions on how to file an administrative hearing, where to send it, and the length of time you have to file for a hearing.

(2) Your request may be made orally or in writing.

(3) You may request assistance in requesting an administrative hearing by calling DDD staff as stated in WAC 388-825-135.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-125, filed 8/19/05, effective 9/19/05.]

WAC 388-825-130 How long do I have to file a request for an administrative hearing? (1) The following rules apply to all situations except a decision to transfer you from a state residential habilitation center (RHC) to the community under RCW 71A.20.080. The rules for administrative hearings regarding the department's decision to transfer you from an RHC to the community are contained in WAC 388-825-155.

(2) You have to request an administrative hearing within ninety days of receipt of the notification of the decision you are disputing.

(3) You must request an administrative hearing within the ten-day notice period, as described in WAC 388-458-0040 (1), (2) and (3), if you wish to maintain current services during the appeal process.

(4) The notification sent to you will include the date that the ten-day notice period ends.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-130, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-130, filed 8/19/05, effective 9/19/05.]

WAC 388-825-135 What if I need help to request an administrative hearing? (1) You may call the department staff person listed in your notification letter and tell them you want to appeal the decision. The department staff person will notify the office of administrative hearings on your behalf.

(2) An oral request for an administrative hearing is complete if it contains enough information to identify the person making the request, the DDD action, and the case involved in the hearing request.

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

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-135, filed 8/19/05, effective 9/19/05.]

WAC 388-825-140 Who else can help me appeal a department decision? Department staff may assist you in requesting an administrative hearing. However, you can authorize anyone except an employee of the department to represent you at an administrative hearing.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-140, filed 8/19/05, effective 9/19/05.]

WAC 388-825-145 Will my benefits continue if I request an administrative hearing? (1) If you request an administrative hearing regarding the department's decision to transfer you from a residential habilitation center to the community under RCW 71A.20.080, the rules in WAC 388-825-155 apply.

(2) If you request an administrative hearing within the ten-day notice period, as described in chapter 388-458 WAC, unless one or more of the conditions in WAC 388-825-150 applies, the department will take no action until there is a final decision on your appeal of the department's decision to:

(a) Terminate your eligibility for services;

(b) Reduce or terminate your services;

(c) Reduce or terminate the payment of SSP set forth in chapter 388-827 WAC; or

(d) Disenroll you from a DDD home and community based services waiver under WAC 388-845-0060, including

a disenrollment from a waiver and enrollment in a different waiver.

(3) The department will take no action until there is a final decision on your appeal of the department's decision to remove or transfer you to another residential service unless one or more of the conditions in WAC 388-825-150 applies.

(4) The department will take no action to terminate your provider of choice unless one or more of the circumstances described in WAC 388-825-150 applies.

(5) After the administrative hearing, you may have to pay back continued benefits you get, as described in chapter 388-410 WAC, if the administrative hearing decision is in favor of the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 08-04-072, § 388-825-145, filed 2/4/08, effective 3/6/08. Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-145, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-145, filed 8/19/05, effective 9/19/05.]

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 388-825-155 What are my appeal rights if I am appealing a decision to transfer me from a state residential habilitation center to the community? (1) The procedures in RCW 71A.10.050(2) and 71A.20.080 govern the proceeding.

(2) You have thirty days from date that you receive notice to request an administrative hearing appealing the department's decision to transfer you from a residential habilitation center to the community under RCW 71A.20.080.

(3) The department will take no action to transfer you from a state residential habilitation center to the community under RCW 71A.20.080 during the period that an appeal can be requested or while an appeal is pending and undecided unless you or your legal representative consent, or a court order authorizes the transfer, or an administrative law judge or review judge rules that you are not diligently pursuing your appeal.

(4) The burden of proof is on the department.

(5) The burden of proof is whether the proposed placement is in your best interest.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-155, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-155, filed 8/19/05, effective 9/19/05.]

WAC 388-825-160 When will a decision on my appeal be made? The administrative law judge shall issue a hearing decision within ninety calendar days of the date the hearing is requested.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-160, filed 8/19/05, effective 9/19/05.]

WAC 388-825-165 Can I appeal the initial order of the administrative law judge? You may file a petition for administrative review, pursuant to chapter 388-02 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-165, filed 8/19/05, effective 9/19/05.]

WAC 388-825-200 What is the purpose of the family support opportunity program? The purpose of the family support opportunity program is to:

(1) Strengthen family functioning through use of the program elements;

(2) Provide a wide range of supports that will assist and stabilize families;

(3) Encourage individuals and local communities to provide support for the persons with developmental disabilities that live with families;

(4) Complement other public and private resources in providing supports;

(5) Recognize the ability of communities to participate in a variety of ways;

(6) Allow families to make use of all program elements according to the individual and family needs; and

(7) Provide assistance to as many families as possible.

[99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.]

WAC 388-825-205 Who is eligible to participate in the family support opportunity program? (1) All individuals living with their families determined to be developmentally disabled according to WAC 388-825-030 and 388-825-035 are eligible to participate in the program if their family requires assistance in meeting their needs. However, the program will fund or provide support services only as funding is available.

(2) Persons currently receiving services under WAC 388-825-252, Family support services, may volunteer to participate in the program.

(3) Families will receive program services based on one or more of the following criteria: The date of application, the date the family was placed on the wait list, eligibility for SSP or other available funding, and/or HCBS waiver status.

(4) Availability of the SSP makes the family ineligible for other state only funding for the same service.

[Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-205, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-205, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.]

WAC 388-825-210 What basic services can my family receive from the family support opportunity program? A number of basic services are available. Some services have their own eligibility requirements. Specific services are:

(1) **Family support plan:** The family and the case manager will develop a family support plan which includes needs assessment, referral, service coordination, service authorization, case monitoring and coordination for community guide services.

(2) **Community guide services** per WAC 388-825-220 through 388-825-226.

(3) **Short-term intervention services** per WAC 388-825-228 and 388-825-230.

(4) **Emergency services:** Your family can request emergency funds to be used to respond to a single incident, situation or short term crisis such as care giver hospitalization, absence, or incapacity. Your request must be made through your case manager and include an explanation of how you plan to resolve the emergency situation. Your request will be reviewed by DDD.

(a) If approved, you will receive emergency services for a limited time period, not to exceed two months.

(b) If denied, you have no appeal rights.

(5) **Serious need services** per WAC 388-825-232 through 388-825-238.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-210, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-210, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.]

WAC 388-825-220 What is the purpose of community guide services? (1) Community guide services are available to support your family and help you become well connected to resources or supports in your community. After an assessment, your case manager will give you information about a community guide, whose services can be used, if desired by the family.

(2) This guide will assist your family in using the natural and informal community supports relevant to the age of your child with developmental disabilities and your family's specific needs.

[99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.]

WAC 388-825-222 Who can become a community guide? To be a guide, a person must demonstrate his/her connections to the informal structures of their community. The department may contract with an individual, agency or organization. Guides must be knowledgeable about resources in their community and comfortable assisting families and persons with developmental disabilities. DDD will provide appropriate training for community guides within available resources.

[99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.]

WAC 388-825-224 Does my family have a choice in selecting its community guide? Your family will be offered a choice of community guides that best meets the needs of your family. At your family's discretion, your family resources coordinator may serve as your community guide if your developmentally disabled child is thirty-five months of age or younger.

[99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.]

WAC 388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services? The program will authorize up to two hundred twelve dollars per year for community guide services for your family.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-226, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-226, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-226, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-226, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-194, filed 2/1/99, effective 3/4/99.]

WAC 388-825-228 How can short-term intervention services through the family support opportunity program help my family? If your family is eligible, you may receive up to one thousand five hundred dollars per year in short-term intervention funding to pay for necessary services not otherwise available.

(1) Short-term intervention funds can be authorized for a one-time only need or for an episodic service need that occurs over a one-year period.

(2) Short-term intervention funding cannot be used for basic subsistence such as food or shelter but is available for those specialized costs directly related to and resulting from your child's disability.

[Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a). 06-11-082, § 388-825-228, filed 5/16/06, effective 6/16/06. Statutory Authority:

RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-228, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-228, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-228, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-228, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-228, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-195, filed 2/1/99, effective 3/4/99.]

WAC 388-825-230 Specifically how can short-term intervention funds be used? Short-term intervention funds can be used to purchase the following services related to and resulting from the client's disability:

(1) Respite care for intermittent relief to the family caregiver and may include community activities providing respite;

(2) Training and supports such as disability related support groups or parenting classes. This does not include registration or costs related to conferences;

(3) The purchase, rental, loan or refurbishment of specialized equipment, adaptive equipment or supplies not covered by other resources, including medicaid. Specific examples are mobility devices such as walkers and wheelchairs, communication devices and medical supplies. Diapers may be approved only for those three years of age and older.

(4) Environmental modifications including home damage repairs caused by the client and home modifications specific to the client's disability;

(5) Occupational therapy, physical therapy, communication therapy, behavior management, visual and auditory services, or counseling needed by developmentally disabled individuals and not covered by another resource such as medicaid, public schools or child development services funding;

(6) Medical/dental services not covered by any other resource. These services may include the payment of insurance premiums and deductibles but are limited to the portion of the premium or deduction that applies to the client.

(7) Nursing services, not covered by another resource, that can only be rendered by a registered or licensed practical nurse. Examples of such services are ventilation, catheterization, and insulin shots. Parents can provide this service without licensure and will not be paid providers of this service for their natural, step or adopted child;

(8) Special formulas or specially prepared foods necessary because of the client's disability and prescribed by a licensed physician;

(9) Parent/family counseling for grief and loss issues, genetic counseling or behavior management. Payments cannot be approved for services occurring after the death of the DDD client;

(10) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(11) Specialized utility costs including extraordinary utility costs resulting from the client's disability or medical condition;

(12) If another resource is not available, transportation costs, including gas, ferry or transit cost, so a client can receive essential services and appointments; per diem costs may be reimbursed for medical appointments.

Funds cannot be used for the purchase or rental of a car or for airfare.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-230, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.]

WAC 388-825-232 How can serious need funds help my family? Your family may need extraordinary support that exceeds your annual family support opportunity allotment for the child or adult with developmental disabilities living in your home. The purpose of serious need funds is to help you get that support when you need it.

(1) If funding is available and your request is approved, it may be short or long-term in nature and can be used for services such as respite care, behavior management and licensed nursing care.

(2) If your request is denied, there is no right to appeal since this request exceeds your annual family support opportunity allotment.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-232, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.]

WAC 388-825-234 How can my family qualify for serious need funds? Your family may qualify for serious need funds if all of the following conditions are met:

(1) The basic program services outlined in WAC 388-825-210 (community guide, short-term intervention services, etc.) are currently being used by your family or they have been exhausted;

(2) You and your case manager have examined other resources such as medicaid personal care, medically intensive services; private insurance, local mental health programs and programs available through the public schools and the department determines that your need exceeds these services; and

(3) The support is crucial for the child or adult with developmental disabilities to continue living in your home.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-234, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-234, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.]

WAC 388-825-236 How does my family request serious need funds? You must contact your case manager to request serious need funds. The request must:

(1) Indicate the type of services your family needs;

(2) Explain why those services can only be obtained through the use of serious need funds;

(3) Outline the changes you anticipate in your family situation if the requested services are not received; and

(4) Estimate the length of time your family will need the requested services.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-236, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.]

WAC 388-825-238 What amount of serious need funding is available to my family? (1) The maximum amount of funding available is four hundred fifty-two dollars per month or two thousand seven hundred twelve dollars in a six-month period, unless the department determines your family member requires licensed nursing care and the funding is used to pay for nursing care. If licensed care is required, the maximum funding level is two thousand four hundred fifty dollars per month.

(2) Funding must be available in order to receive serious need services.

(3) Services paid for by serious needs funds will be reviewed by DDD every six months.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-238, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-238, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-238, filed 11/21/00, effective 12/22/00. 99-19-104, recodified as § 388-825-238, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-200, filed 2/1/99, effective 3/4/99.]

WAC 388-825-240 Who determines what family support services my family can receive? Your family and your case manager determine what services your family needs. The department has final approval over service authorization.

[99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.]

WAC 388-825-242 What department restrictions apply to family support payments? (1) Family support opportunity services payments are authorized only after you have accessed what is available to you under medicaid and any other private health insurance plan, including medicaid personal care, to meet your identified need.

(2) All family support service payments must be authorized by the department.

(3) The department may contract directly with:

(a) A service provider, or

(b) A parent for the reimbursement of goods or services purchased by the parent, or

(c) An agency to purchase goods and services on behalf of a client.

(4) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

(5) The department does not pay for treatment determined by DSHS/medical assistance administration (MAA) or private insurance to be experimental.

(6) Respite care cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the client.

(7) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver (or their spouse) living in the same household with the client for respite, nursing, therapy, or counseling services.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-242, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.]

WAC 388-825-244 What are regional family support advisory councils? (1) Each division of developmental disabilities regional administrator must appoint a family support advisory council which may serve as a subcommittee of the regional advisory council. The membership of the family support advisory council must include at least one parent representative and at least one case manager.

(2) The purpose of these family support advisory councils is to advise the regional administrator regarding:

(a) Family support issues;

(b) Guidelines for approving or denying short term intervention requests;

(c) Community needs; and

(d) Recommendations for community service grants.

(3) Family support advisory councils must meet at least twice a year.

[99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.]

WAC 388-825-246 What are community service grants? (1) Community service grants are funded by the division of developmental disabilities family support program to promote community oriented projects that benefit families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

Agencies or individuals may apply for funding. The department will announce the availability of funding.

(2) To qualify for funding, a proposed project must address one or more of the following topics:

(a) Provider support and development;

(b) Parent helping parent; or

(c) Community resource development for inclusion of all.

(3) Goals for community service projects are as follows:

(a) Enable families to use generic resources;

(b) Reflect geographic, cultural and other local differences;

(c) Support families in a variety of noncrisis-oriented ways;

(d) Prioritize support for unserved families;

(e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;

(f) Be family focused;

(g) Increase inclusion of persons with developmental disabilities;

(h) Benefit families who have children or adults eligible for services from DDD; and

(i) Promote community collaboration, joint funding, planning and decision making.

(4) Decisions to approve or reject community service grant requests are made by DDD regional administrators considering the recommendations of their regional family support advisory councils. The DDD director has the discretion to award community service grants that have statewide significance.

(5) DDD may sponsor two family support conferences in different areas of the state each year. The purpose of these conferences is to discuss areas addressed by community service grants and other issues of importance to families.

[99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.]

WAC 388-825-248 Who is covered under these rules? These sections (WAC 388-825-200 through 388-825-242) apply to persons enrolled in family support after June 1996. Those enrolled before June 1996 are covered under WAC 388-825-252 through 388-825-256.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-248, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-248, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.]

WAC 388-825-250 Continuity of family support services. (1) It is the policy of the department to recognize the dependence of individuals currently receiving family support services at a given level of services, and to avoid disruption of those services at that given level when possible.

(2) In order for the department to maximize the continuity of service while remaining within appropriated funds for family support services, when appropriated funds for family support services do not permit serving new applicants or increasing services to current recipients without reducing services to existing clients, the department may deny requests for new or increased services based on the lack of funds pursuant to WAC 388-825-055.

(3) These requests may be denied even if the service need levels, as described in WAC 388-825-030, of new applicants or current recipients are of a higher priority than those currently receiving services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-250, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.]

WAC 388-825-252 Family support services. (1) The purpose of the family support program is to reduce or eliminate the need for out-of-home residential placement of an individual with developmental disabilities where it is in the best interest of the person to continue living with their family.

(2) The department's family support services include the following and become available only after you have used your full benefits through medicaid, private insurance, school and child development services:

(a) Respite care is intermittent relief to the family caregiver and may include community activities which provide respite;

(b) Nursing services provided by a registered nurse or licensed practical nurse, that cannot be provided by an unlicenced caregiver, including but not limited to, ventilation, catheterization, insulin injections, etc.;

(c) Therapeutic services including occupational therapy, physical therapy, communication therapy, behavior management, or counseling needed by individuals with developmental disabilities.

(3) Receiving family support services is based on:

(a) Funding for state paid services available in the state operating budget;

(b) SSP funding available to the individual/family.

(4) The following rules, subsections (5) through (9), apply only to family support services authorized by the department and do not govern services purchased by the family with SSP (state supplementary payment) funding (see WAC 388-827-0145 and 388-827-0170).

(5) Up to nine hundred dollars of the service need level amount in WAC 388-825-254 may be used during a one year period for use as follows. The requested service must be necessary as a result of the disability of the individual and after you have used your full benefits through medicaid, private insurance, school and child development services:

(a) Training and supports including parenting classes and disability related support groups. This does not include registration or costs related to conferences;

(b) Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment not covered by another resource including medicaid. Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for children three years of age and older;

(c) Environmental modification including home repairs for damages or modifications to the home needed because of the disability of the individual;

(d) Medical/dental services not covered by any other resource. This may include the payment of insurance premiums and deductibles and is limited to the premiums and deductibles of the individual;

(e) Special formulas or specially prepared foods as prescribed by a licensed physician and needed because of the disability of the individual;

(f) Parent/family counseling related to the individual's disability, dealing with a diagnosis, grief and loss issues, genetic counseling and behavior management. Payments cannot be approved for services occurring after the death of the eligible individual;

(g) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(h) Specialized utility costs including extraordinary supplemental utility costs related to the individual's disability or medical condition;

(i) If another resource is not available, transportation costs, including gas, ferry or transit cost, so an individual can receive essential services and appointments; per diem costs may be reimbursed for medical appointments. Funds cannot be used for the purchase or rental of a car or for airfare.

(6) Recommendations will be made to the regional administrator by a review committee. The regional administrator will approve or disapprove the request and will communicate reasons for denial to the committee.

(7) Payment for services specified in subsection (5) shall cover only the portion of cost attributable to the individual.

(8) Requests must be received by DDD no later than midway through the service authorization period unless circumstances exist justifying an emergency.

(9) A plan shall be developed jointly by the family and the department for each service authorization period. The department may choose whether to contract directly with the vendor, to authorize purchase by another agency, or may reimburse the parent of the individual.

(10) Emergency services. Emergency funds may be requested for use in response to a single incident or situation or short term crisis such as care giver hospitalization, absence, or incapacity. The request shall include anticipated resolution of the situation. Funds shall be provided for a limited period not to exceed two months. All requests are to be reviewed and approved or denied by DDD.

(a) If approved, you will receive emergency services for a limited time period, not to exceed two months.

(b) If denied, you have no appeal rights.

(11) If the individual becomes eligible and begins to receive medicaid personal care services as defined in chapters 388-71 and 388-72A WAC or other DSHS in-home residential support service, the family support funding will be reduced at the beginning of the next month of service. The family will receive notice of the reconfiguration of services at least five working days before the beginning of the month.

(12) Family support services may be authorized below the amount requested by the family for the period. When, during the authorized service period, family support services are reduced or terminated below the amount specified in service authorizations, the department shall deem such actions as a reduction or termination of services.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-252, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-252, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-252, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.-040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.]

WAC 388-825-253 Family support service restrictions. (1) Family support services payments are authorized only after you have used what is available to you under medicaid and any other private health insurance plan.

(2) All family support service payments must be authorized by the department.

(3) The department may contract directly with:

(a) A service provider; or

(b) A parent for the reimbursement of goods purchased by the parent; or

(c) An agency to purchase goods and services on behalf of an individual.

(4) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

(5) The department does not pay for treatment determined by DSHS/MAA or private insurance to be experimental.

(6) Respite cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the individual.

(7) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver (or their spouse) living in the same household with the individual to provide respite, nursing, therapy, or counseling services.

[Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-253, filed 10/29/04, effective 11/29/04.]

WAC 388-825-254 Service need level rates. (1) The department shall base periodic service authorizations on:

(a) Requests for family support services described in WAC 388-825-252 (2) and (5);

(b) Service need levels. The amount of SSP (state supplementary payment) available to an individual will be included when calculating the monthly allocation of state family support dollars.

(c) Availability of family support funding;

(d) Authorization by a review committee, in each regional office, which reviews each request for service;

(e) The amounts designated in subsection (2)(a) through (d) of this section are subject to periodic increase if vendor rate increases are mandated by the legislature.

(2) Service need level lid amounts as follows:

(a) Clients designated for service need level one (WAC 388-825-256) may receive up to fifteen thousand four hundred dollars per year or twenty-nine thousand four hundred dollars per year if the individual requires licensed nursing care in the home:

(i) If an individual is receiving funding through medicaid personal care or other DSHS in-home residential support, the maximum payable through family support shall be six thousand eight hundred dollars per year;

(ii) If the combined total of family support services at this maximum plus in-home support is less than six thousand eight hundred dollars additional family support can be authorized to bring the total to six thousand eight hundred dollars per year.

(b) Clients designated for service need level two (WAC 388-825-256) may receive up to six thousand dollars per year if not receiving funding through medicaid personal care:

(i) If an individual is receiving funds through medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be three thousand four hundred dollars per year;

(ii) If the combined total of family support services at this maximum plus in-home support is less than six thousand dollars, additional family support can be authorized to bring the total to six thousand dollars per year.

(c) Clients designated for service need level three (WAC 388-825-256) may receive up to three thousand four hundred dollars per year provided the individual is not receiving medicaid personal care. If the individual is receiving medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be one thousand seven hundred dollars per year; and

(d) Clients designated for service level four (WAC 388-825-256) may receive up to one thousand seven hundred dollars per year family support services.

(3) The department shall authorize family support services contingent upon the applicant providing accurate and complete information on disability-related requests.

(4) The department shall ensure service authorizations do not exceed maximum amounts for each service need level based on the availability of funds.

[Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a). 06-11-082, § 388-825-254, filed 5/16/06, effective 6/16/06. Statutory Authority: RCW 71A.12.030, 71.A12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-254, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-254, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.12.-030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-254, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-254, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-254, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-254, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-222, filed 6/13/97, effective 7/14/97.]

WAC 388-825-256 Service need levels. (1) The department shall use service need levels to determine periodic family support service authorizations.

(2) The department shall determine service need levels in order of priority for funding as follows:

(a) Service need level 1: Client is at immediate risk of out-of-home placement without the provision of family support services. The client needs intensive residential support to assist the client's family to care for the family's child or adult requiring nursing services, attendant care, or support due to difficult behaviors. A client shall:

(i) Have received, over the past three months, at least ten days or eighty hours of service; or

(ii) Requires at least ten days or eighty hours per month of service to prevent immediate out-of-home placement, based upon an assessment conducted by the department;

(b) Service need level 2: Client is at high risk of out-of-home placement without the provision of family support services and has one or more of the following documented in writing:

(i) The client:

(A) Currently receives adult protective services or division of children and family services as an active:

(I) Child protective service client;

(II) Child welfare service client; or

(III) Family reconciliation service client.

(B) Has returned home from foster care or group care placement within the last six months;

(C) Has a serious medical problem requiring close and ongoing monitoring and/or specialized treatment, such as:

(I) Apnea monitor;

(II) Tracheotomy;

(III) Heart monitor;

(IV) Ventilator;

(V) Constant monitoring due to continuous seizures;

(VI) Immediate life-saving intervention due to life threatening seizures;

(VII) Short bowel syndrome; or

(VIII) Brittle bone syndrome.

(D) Has a dual diagnosis based on current mental health DSM Axis I diagnosis;

(E) Has an extreme behavioral challenge resulting in health and safety issues for self and/or others which:

(I) Resulted in serious physical injury to self or others within the last year;

(II) For a client who is two years of age or older, requires constant monitoring when awake for personal safety reasons; or

(III) Is of imminent danger to self or others as determined by a psychiatrist, psychologist, or other qualified professional.

(F) Is ten years of age or older or weighs forty pounds or more, requires lifting, and needs direct physical assistance in three or more of the following areas:

(I) Bathing;

(II) Toileting;

(III) Feeding;

(IV) Mobility; or

(V) Dressing.

(ii) The caregiver:

(A) Is a division of developmental disabilities client;

(B) Has a physical or medical problem that interferes with providing care; or

(C) Has serious mental health or substance abuse problems and:

(I) Is receiving counseling for these problems; or

(II) Has received or applied for counseling within the past six months.

(c) Service need level 3: The family is at risk of significant deterioration which could result in an out-of-home placement of the client without provision of family support services due to the following:

(i) The client requires direct physical assistance, above what is typical for such client's age, in three or more of the following areas:

(A) Bathing;

(B) Toileting;

(C) Feeding;

(D) Mobility; or

(E) Dressing.

(ii) The client has current behavioral episodes resulting in:

(A) Physical injury to the client or others;

(B) Substantial damage to property; and/or

(C) Chronic sleep pattern disturbances or chronic continuous screaming behavior.

(iii) The client has medical problems requiring substantial extra care; and/or

(iv) The family is:

(A) Experiencing acute and/or chronic stress;

(B) Has acute or chronic physical limitations; or

(C) Has acute or chronic mental or emotional limitations.

(d) Service need level 4: Family needs temporary or ongoing services in order to:

(i) Receive support to relieve and/or prevent stress of caregiver/family; or

(ii) Enhance the current functioning of the family.

(3) The department, through regional review committees, shall determine service need level of the client's service request by reviewing information received from the client, family, and other sources about:

(a) Whether client is an active recipient of services from the division of children and family services or adult protective services;

(b) Whether indicators of risk of out-of-home placement exist, and the imminence of such an event. The department's assessment of such risk may include:

(i) Review of family's requests for placement;

(ii) History of family's involvement with children's protective services or adult protective services;

(iii) Client's current adjustment;

(iv) Parental history of psychiatric hospitalization;

(v) Clinical assessment of family's condition; and

(vi) Statements from other professionals.

(c) Caregiver conditions, such as acute and/or chronic:

(i) Stress;

(ii) Physical limitations; and

(iii) Mental and/or emotional impairments.

(d) Client's need for intense medical, physical, or behavioral support;

(e) Family's ability to use typical community resources;

(f) Availability of private, local, state, or federal resources to help meet the need for family support;

(g) Severity and chronicity of family or client problems; and

(h) Degree to which family support services will:

(i) Ameliorate or alleviate such problems; and

(ii) Reduce the risk of out-of-home placement.

[99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.]

INDIVIDUAL PROVIDER AND AGENCY PROVIDER QUALIFICATIONS

WAC 388-825-300 What is the purpose of WAC 388-825-300 through 388-825-400? A client/legal representative may choose a qualified individual, agency, or licensed provider. The intent of WAC 388-825-300 through 388-825-400 is to describe:

(1) Qualification for individuals and agencies providing DDD services in the client's residence or the provider's residence or other setting; and

(2) Conditions under which the department will pay for the services of an individual provider or a home care agency provider or other provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-300, 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 388-825-310 What are the qualifications for providers? (1) Individuals and agencies providing medicaid personal care (chapters 388-71 and 388-106 WAC) and DDD HCBS waiver personal care (chapter 388-845 WAC) must meet the qualifications and training requirements in WAC 388-71-0500 through 388-71-05909.

(2) Individuals and agencies providing nonwaiver DDD home and community based services (HCBS) in the client's residence or the provider's residence or other setting must meet the requirements in WAC 388-825-300 through 388-825-400.

(3) Individuals and agencies providing HCBS waiver services must meet the provider qualifications in chapter 388-845 WAC for the specific service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-310, filed 8/19/05, effective 9/19/05.]

WAC 388-825-315 What is your responsibility when you hire an individual respite care, attendant care or personal care provider? You or your legal representative:

(1) Have the primary responsibility for locating, screening, hiring, supervising, and terminating an individual respite care, attendant care or personal care provider;

(2) Establish an employer/employee relationship with the individual provider; and

(3) May receive assistance from the social worker/case manager or other resources in this process.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-315, 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 388-825-330 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? (1) Agencies providing personal care services must be licensed as a home care agency or a home health agency through the department of health.

(2) If a residential agency certified per chapter 388-820 WAC wishes to provide medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-330, filed 8/19/05, effective 9/19/05.]

WAC 388-825-335 Is a background check required of a home care agency provider? In order to be a home care agency provider, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-335, 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? 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 388-825-345 What "related" providers are exempt from licensing? (1) Relatives of a specified degree are exempt from the licensing requirement and may provide out-of-home respite in their home.

(2) Relatives of specified degree include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-345, 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 388-825-360 How does an individual terminate employment as a provider? State law makes it a crime to abandon a vulnerable adult. "Abandon" means leaving a person without the means or ability to obtain any of the basic necessities of life.

(1) If an individual wishes to "quit" or terminate employment as a provider, the individual must give at least two weeks written notice to his/her employer, their representative (if applicable) and the DDD case manager.

(2) The individual will be expected to continue working until the termination date unless otherwise determined by DSHS.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-360, filed 8/19/05, effective 9/19/05.]

WAC 388-825-365 Are providers expected to report abuse, neglect, exploitation or financial exploitation? Providers are expected to report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-365, 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 388-825-380 When can the department reject the client's choice of an individual respite care, attendant care or personal care provider? The department may reject a client's request to have a family member or other person serve as his or her individual respite care, attendant care or personal care provider if the case manager has a reasonable, good faith belief that the person will be unable to appropriately meet the client's needs. Examples of circumstances indicating an inability to meet the client's needs could include, without limitation:

(1) Evidence of alcohol or drug abuse;

(2) 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);

(3) A report from the client's health care provider or other knowledgeable person that the requested provider lacks the ability or willingness to provide adequate care;

(4) Other employment or responsibilities that prevent or interfere with the provision of required services;

(5) Excessive commuting distance that would make it impractical to provide services as they are needed and outlined in the client's service plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-380, 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.]

WAC 388-825-400 Self-directed care—Who must direct self-directed care? Self-directed care under chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the individual provider in the health-related tasks which the client self-directs.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-400, filed 8/19/05, effective 9/19/05.]

WAC 388-825-500 What is the family support pilot? (1) The family support pilot (FSP) is a new state-only program funded by the legislature to provide services in a new program through June 2007.

(2) The purpose of the family support pilot is to provide paid services in a flexible manner to eligible DDD clients.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-500, filed 2/23/06, effective 3/26/06.]

WAC 388-825-505 What is the statutory authority for the family support pilot? The legislature directed DDD to implement the family support pilot in the 2005-2007 conference budget, section 205(1)(e), chapter 518, Laws of 2005.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-505, filed 2/23/06, effective 3/26/06.]

WAC 388-825-510 Who is eligible to participate in the family support pilot? To be eligible to participate in the family support pilot (FSP), you must meet all of the following criteria:

(1) Be a client of DDD.

(a) Your eligibility must be current.

(b) WAC 388-823-1010 may require a review of your eligibility prior to any approval of paid services.

(2) Be in DDD's current data base as having requested FSP.

(3) Live with family as defined in WAC 388-825-512.

(4) Not be receiving any other DDD paid services as defined in WAC 388-825-516.

(5) Have been determined ineligible for medicaid personal care (MPC).

(6) Have a gross household annual income of less than or equal to 400% of federal poverty level (FPL).

(7) Have completed a mini-assessment per chapter 388-824 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-510, filed 2/23/06, effective 3/26/06.]

WAC 388-825-512 What is the definition of family? Family means relatives who live in the same home with the eligible client. Relatives include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-512, filed 2/23/06, effective 3/26/06.]

WAC 388-825-513 What is the definition of an "award"? (1) An award is the dollar amount of services performed by a provider for an eligible client.

(2) The award will be paid directly to the provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-513, filed 2/23/06, effective 3/26/06.]

WAC 388-825-514 If I participate in the FSP, will I be eligible for services through the DDD home and community based services (HCBS) waiver? You may request to be served in the DDD HCBS waiver per WAC 388-845-0050 but waiver enrollment is limited by waiver capacity and funding. Participation in the FSP will not affect your potential waiver eligibility.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-514, filed 2/23/06, effective 3/26/06.]

WAC 388-825-516 If I receive other DDD funded services do I qualify for the FSP? You do not qualify for the FSP if any of the following apply:

(1) You receive other DDD funded services identified in WAC 388-823-1015, including services through the DDD HCBS waiver per WAC 388-845-0050;

(2) You are eligible for medicaid personal care;

(3) You receive the state supplementary payment administered by DDD; or

(4) You are under age three. (All children under age three receive or are eligible to receive services through the infant toddler early intervention program and/or child development services through DDD.)

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-516, filed 2/23/06, effective 3/26/06.]

WAC 388-825-520 If I qualify for and receive an FSP award, will my name remain on the family support waitlist? Participation in the FSP does not remove your name from the family support waitlist.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-520, filed 2/23/06, effective 3/26/06.]

WAC 388-825-524 How do I apply for the FSP? You may apply for the FSP by completing and returning an FSP questionnaire that DDD will send to individuals and families who are on the family support waitlist as of August 1, 2005.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-524, filed 2/23/06, effective 3/26/06.]

WAC 388-825-528 What will DDD do with the FSP questionnaire that you return? When you return the FSP questionnaire, DDD will determine your eligibility according to the criteria contained in WAC 388-825-510 and notify you of its decision according to WAC 388-825-588.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-528, filed 2/23/06, effective 3/26/06.]

WAC 388-825-532 How does DDD determine the federal poverty level (FPL) for my household? DDD determines the federal poverty level (FPL) for your household by asking you for your gross annual household income and the number of people living in your household.

(1) DDD cannot determine your financial eligibility for FSP without this information.

(2) If you do not provide this information, you will not be eligible for FSP services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-532, filed 2/23/06, effective 3/26/06.]

WAC 388-825-534 What are the annual federal poverty levels? (1) The annual federal poverty levels (FPL) are based on household size and established by the federal Office of Management and Budget.

(2) Effective April 2005, the annual federal poverty levels are:

Household Size	100% FPL	200% FPL	300% FPL	400% FPL
One	$9,570	$19,140	$28,710	$38,280
Two	$12,830	$25,660	$38,490	$51,320
Three	$16,090	$32,180	$48,270	$64,360
Four	$19,350	$38,700	$58,050	$77,400
Five	$22,610	$45,220	$67,830	$90,440
Six	$25,870	$51,740	$77,610	$103,480
Seven	$29,130	$58,260	$87,390	$116,520
Eight	$32,390	$64,780	$97,170	$129,560
Nine	$35,650	$71,300	$106,950	$142,600
Ten	$38,910	$77,820	$116,730	$155,640

For each household member over ten, add the following amounts to the ten-person standard:

100% FPL	200% FPL	300% FPL	400% FPL
$3,260	$6,520	$9,780	$13,040

(3) Effective April 2006, the annual federal poverty levels are:

Household Size	100% FPL	200% FPL	300% FPL	400% FPL
One	$9,800	$19,600	$29,400	$39,200
Two	$13,200	$26,400	$39,600	$52,800
Three	$16,600	$33,200	$49,800	$66,400
Four	$20,000	$40,000	$60,000	$80,000
Five	$23,400	$46,800	$70,200	$93,600
Six	$26,800	$53,600	$80,400	$107,200
Seven	$30,200	$60,400	$90,600	$120,800
Eight	$33,600	$67,200	$100,800	$134,400
Nine	$37,000	$74,000	$111,000	$148,000
Ten	$40,400	$80,800	$121,200	$161,600

For each household member over ten, add the following amounts to the ten-person standard:

100% FPL	200% FPL	300% FPL	400% FPL
$3,400	$6,800	$10,200	$13,600

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-534, filed 2/23/06, effective 3/26/06.]

WAC 388-825-536 What is "gross annual household income"? Gross annual household income means total unearned and earned income prior to any deductions or taxes for the past calendar year.

(1) Ownership of income is defined in WAC 388-450-0005.

(2) Income that is not counted is defined in WAC 388-450-0015.

(3) Unearned income is defined in WAC 388-450-0025.

(4) Earned income is defined in WAC 388-450-0030.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-536, filed 2/23/06, effective 3/26/06.]

WAC 388-825-538 What is the definition of household? For the purpose of determining household size and gross annual household income, the definition of household follows:

(1) If you are under age eighteen, your household includes:

(a) You;

(b) Your natural or adoptive parent(s) or stepparent(s) living with you;

(c) Your full, half, step, or adoptive siblings living with you if they are:

(i) Not married;

(ii) Not the head of a household; and

(iii) Under age eighteen, or under age twenty-two if they are students regularly attending school or college or training that is designed to prepare the siblings for a paying job.

(2) If you are age eighteen or older, your household includes only you.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-538, filed 2/23/06, effective 3/26/06.]

WAC 388-825-540 Who must declare their income? If you are a child under age of eighteen at the time you are declaring income, your custodial, natural/step/adoptive parent(s) or guardian(s) must declare income.

(2) If you are age eighteen or older, you are the only household member to declare income. You must report all unearned and earned income.

(3) Income is subject to verification upon department request.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-540, filed 2/23/06, effective 3/26/06.]

WAC 388-825-544 If I meet eligibility for FSP, will I receive paid services? You will have access to an amount of paid services called an "FSP Award" if:

(1) You are determined eligible by DDD to participate in FSP;

(2) You meet one of the priority groups in WAC 388-825-554; and

(3) There is funding available.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-544, filed 2/23/06, effective 3/26/06.]

WAC 388-825-548 What is the amount of the FSP awards? FSP Awards are based on your gross household income and the annual Federal Poverty Level (FPL) based on your household size and income.

Amount of Annual Income	Amount of Award
Equal to or less than 100% FPL	Up to $4,000 per year
Greater than 100% but equal to or less than 200% FPL	Up to $3,000 per year
Greater than 200% but equal to or less than 300% FPL	Up to $2,000 per year
Greater than 300% but equal to or less than 400% FPL	Up to $1,000 per year

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-548, filed 2/23/06, effective 3/26/06.]

WAC 388-825-552 What if there are two or more family members who qualify for FSP? Each family member who is eligible will be considered for an award.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-552, filed 2/23/06, effective 3/26/06.]

WAC 388-825-554 How will DDD determine who will receive awards for FSP? Within the availability of staff time, DDD will distribute the awards to eligible FSP clients in order of the following priorities:

(1) Client or caregiver with health and safety needs that places the client at immediate risk of out-of-home placement in a nursing facility or ICF/MR.

(2) Clients living in single parent households;

(3) Clients with multiple disabilities; and

(4) Clients who are at least twenty-one years old and graduated from high school who need employment services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-554, filed 2/23/06, effective 3/26/06.]

WAC 388-825-558 What FSP services can my family and I receive? You and your family can use your FSP award to pay for any of the following services identified and agreed to in your FSP service plan with DDD:

(1) Respite care which is intermittent relief to your caregiver.

(a) Respite care may be provided in your home or the home of a relative or licensed provider, or community setting/activity contracted for respite care.

(b) The respite provider must be a qualified individual or agency per WAC 388-825-300 through 388-825-400.

(c) Respite care may be provided by a registered or licensed nurse if you require a licensed health professional as determined by DDD.

(2) Training and consultation for you or your family, including:

(a) Counseling related to your disability or genetic counseling.

(b) Parenting classes and disability related support groups.

(c) Behavior management/counseling.

(3) Assistive technologies or specialized or adaptive equipment related to your development disability:

(a) Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for children three years of age or older.

(b) Professional justifications may be required by the department.

(4) Employment services for those clients twenty-one years of age and older. See chapter 388-850 WAC.

(5) Extraordinary household expenses resulting from the client's developmental disability such as a portion of the power bill for a ventilator dependent client.

(a) The expense is limited to the total cost divided by the total number of persons living in the family.

(b) This will not include the purchase of any appliances, furniture, or floor coverings.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-558, filed 2/23/06, effective 3/26/06.]

WAC 388-825-560 What department restrictions apply to FSP? The following department restrictions apply to FSP:

(1) FSP services are authorized only after you have accessed what is available to you under medicaid, and any other private health insurance plan, school or child development services.

(2) All FSP service payments must be agreed to by DDD and the client in a written service plan.

(3) The department will contract directly with a service provider, or a parent for the reimbursement of goods or services purchased by the parent. FSP funding cannot be authorized for services or treatments determined by the department to be experimental.

(4) Your choice of qualified providers and services is limited to the most cost effective option that meets your assessed need.

(5) Respite care cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the child.

(6) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver or their spouse living in the same household with the client to provide respite, nursing, therapy or counseling services.

(7) FSP will not pay for conference registrations.

(8) FSP will not pay for behavior management/counseling procedures, modifications, or equipment that are restrictive.

(9) FSP will not pay for services provided after the death of the eligible client. Payment may occur after the date of death, but not the service.

(10) FSP will not pay for employment services if you are under age twenty-one or are designated to receive DDD funded transition services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, 2005 c 518 § 205 (1)(e), Title 71A RCW. 06-19-036, § 388-825-560, filed 9/13/06, effective 10/14/06; 06-06-040, § 388-825-560, filed 2/23/06, effective 3/26/06.]

WAC 388-825-562 What is an FSP plan? (1) An FSP plan is a written plan you develop with your DDD case resource manager that identifies the services you will purchase with your FSP award.

(2) The FSP plan will last for up to twelve months, but cannot extend beyond June 30, 2007.

(3) The department has the final approval over service authorization.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-562, filed 2/23/06, effective 3/26/06.]

WAC 388-825-564 Does my family have a choice of FSP services? The individual and family identify and choose FSP services per WAC 388-825-558 through the department's assessment and planning process. Adult clients are included in the choice of FSP services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-564, filed 2/23/06, effective 3/26/06.]

WAC 388-825-572 What if I have needs that exceed my FSP award limit? If you have needs that exceed your FSP award limit, DDD may approve additional funding to meet certain extraordinary needs as "one-time award." This approval is an exception to your award limit and you cannot appeal the amount of the exception or denial of an exception.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-572, filed 2/23/06, effective 3/26/06.]

WAC 388-825-575 What are one-time awards? A one-time award is limited to extraordinary support for individuals receiving FSP funding.

(1) The one-time award can only be approved for the following services performed by a DDD contracted provider:

(a) Respite care; and/or

(b) Behavior management/counseling.

(2) A one-time award may be approved only once during the period of time covered by your FSP plan.

(3) Providers of the services in subsection (1) of this section must be contracted with and paid directly by DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-575, filed 2/23/06, effective 3/26/06.]

WAC 388-825-576 How do I apply for a one-time award? You may apply for a one-time award by following the procedures contained in WAC 388-825-236.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-576, filed 2/23/06, effective 3/26/06.]

WAC 388-825-578 What amount of one-time funding is available for my family? The maximum amount of one-time funding available for respite care and/or behavior management/counseling is the same as the amount of your award, determined by WAC 388-825-548.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-578, filed 2/23/06, effective 3/26/06.]

WAC 388-825-581 How long do I remain eligible for the FSP? (1) If you are approved for an FSP award, your FSP plan will be reviewed annually for continued funding as long as FSP funding is available.

(2) The family support pilot ends June 30, 2007.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-581, filed 2/23/06, effective 3/26/06.]

WAC 388-825-584 Can I be terminated from FSP? You will be terminated from FSP if any of the following occur:

(1) Your DDD eligibility is terminated per chapter 388-823 WAC;

(2) You no longer live with a family as defined in WAC 388-825-512;

(3) You begin living independently or with a spouse;

(4) You begin to receive other DDD funded services;

(5) Your household income exceeds 400% of the FPL;

(6) You become eligible for medicaid personal care; and/or

(7) FSP funding is no longer available.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-584, filed 2/23/06, effective 3/26/06.]

WAC 388-825-586 When are changes in my circumstances considered effective? (1) Except for changes in income and/or household size, changes are effective immediately.

(2) Changes in gross annual household income and changes in household size are effective at the time your FSP plan is reviewed.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-586, filed 2/23/06, effective 3/26/06.]

WAC 388-825-588 How will the department notify me of their decisions? The department will provide written notification to you and your legal representative of all eligibility and service decisions per WAC 388-825-100 through 388-825-105. These notices will include your appeal rights.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-588, filed 2/23/06, effective 3/26/06.]

WAC 388-825-591 What are my appeal rights under the FSP? You have appeal rights under WAC 388-825-120 to the following decisions:

(1) Denial of eligibility to participate in the FSP per WAC 388-825-510.

(2) A denial, reduction or termination of FSP services.

(3) A denial or termination of your choice of a qualified provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-591, filed 2/23/06, effective 3/26/06.]

WAC 388-825-595 How do I appeal a department action? Your appeal rights and procedures to appeal a department decision are in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-595, filed 2/23/06, effective 3/26/06.]

Chapter 388-826 WAC
VOLUNTARY PLACEMENT PROGRAM

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-826-0100 What happens if the voluntary placement ends? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0100, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0200.

388-826-0105 When the child leaves the voluntary placement program for any reason, what DDD services are available to the child and family when voluntary placement ends? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0105, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0210.

WAC 388-826-0001 What is the purpose of the voluntary placement program? The purpose of the voluntary placement program is to:

(1) Support the optimal growth and development of the child or youth in out-of-home placement. The sole reason for the out-of-home placement is the child's developmental disability. Services are offered by DSHS/DDD through a voluntary placement agreement. Parents retain custody of their child or youth.

(2) Support the child and family with a shared parenting arrangement through the use of licensed foster care providers.

(3) Complement other public and private resources in providing supports to the child and family.

(4) Encourage the relationship between the child and parents, even when the child or youth is not living in their own home.

(5) These rules are adopted under the authority of RCW 74.13.350.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0001, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0005 Definitions. "Best interest" includes, but is not limited to:

(1) Prevent regression or loss of skills already acquired;

(2) Achieve or maintain self-sufficiency;

(3) Provide the least restrictive setting that will meet the child's/youth's medical, social, developmental and personal needs;

(4) Benefits the medical, personal, social and developmental needs of the child/youth;

(5) Maintains family relationships.

"Child or youth" means an individual who is eligible for division services per RCW 71A.16.040 and chapter 388-825 WAC, is less than eighteen years of age and who is in the custody of a parent by blood, adoption or legal guardianship.

"Client or person" means an individual is eligible for division services per RCW 71A.16.040 and WAC 388-825-030.

"Community support services" means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, social work, early childhood intervention, employment, family counseling, respite care, information and referral, health services, legal services, therapy services, residential services and support, transportation services, and vocational services.

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

"Director" means the director of the division of developmental disabilities.

"DDD" means the division of developmental disabilities of the department of social and health services.

"Emergency" means a sudden, unexpected occurrence demanding immediate action.

"Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

"Family" means individuals of any age, living together in the same household related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Foster care provider" means the individual person licensed by the DSHS, children's administration, division of licensed resources (DLR) (chapter 388-148 WAC) to provide foster care in the person's home; or a group care agency licensed by DLR to provide foster care for an individual in a group facility or staffed residential setting.

"In the voluntary placement program the legal status of the child" means that the child is in legal custody of the biological or adoptive parent(s) or legal and custodial guardian.

"The judicial determination and review" means a process that occurs in court and its purpose is to affirm that out-of-home placement is in the best interest of the child. The parent is notified of the court date and may appear in court with the child's DDD social worker.

"Out-of-home placement" means a DLR licensed home, a licensed group care facility or another licensed setting.

"Parent" means the individual who is the biological or adoptive person or legal custodial guardian who has legal responsibility for and physical custody of the child.

"Shared parenting" means biological or adoptive parents or legal guardians and foster care providers share responsibilities. Responsibilities are for the physical and emotional care, education and medical well-being of child/youth who meets DDD eligibility criteria and who is in a voluntary out of home placement as is described in the shared parenting agreement.

"Shared parenting plan" means a written plan among the parent, a foster care provider and DDD, with the expectation of sharing responsibilities for care of a child/youth, including exchanging information on a routine basis about medical, education, daily routines and special situations in the life of the child/youth.

"Voluntary out-of-home placement" for a child who is eligible for DDD services means:

(1) When a parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside out of the home of the parents;

(2) The placement is solely due to the child's disability;

(3) There are no unresolved issues of abuse and neglect;

(4) When the parent or custodial and legal guardian and division sign a voluntary placement agreement; and

(5) When a child lives more than fifty percent of her/his life in a licensed setting that is other than in the parents' home. The setting may be a licensed foster family home, group care facility, or staffed residential home as licensed under chapter 74.15 RCW.

"Voluntary placement agreement," as used in this section, means a written agreement between the department and a child's parent or legal guardian authorizing the department to place the child in a licensed facility.

"Written request for out-of-home placement" means a written request signed by the custodial parent requesting out-of-home placement for the child or youth under eighteen years of age.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0005, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0010 Who is eligible for the voluntary placement program? Children who:

(1) Are determined eligible for DDD services under RCW 71A.16.040;

(2) Are under eighteen years of age when the request for services through VPP is made;

(3) Have no unresolved issues of abuse or neglect pending with DSHS children's administration;

(4) Are in the legal and physical custody of their parent or legal guardian; and

(5) The request is made solely due to the child's disability RCW 74.13.350 and parents have used all other appropriate services for their child through DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0010, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0015 Who else may be eligible to participate in the voluntary placement program? Within available resources:

(1) Children or youth who are eligible for DDD services per RCW 71A.16.040, may transfer from children's administration, as long as they are under eighteen years of age, in a stable guardianship, and have no unresolved issues of abuse or neglect pending with children's administration.

(2) Youth who turn eighteen while in the VPP and reside in a DLR licensed setting, may continue to participate in VPP until age twenty-one as long as her/his placement remains in tact and does not disrupt and she/he remains in school until graduation or reaches age twenty-one, whichever comes first (see WAC 388-826-0115).

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0015, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0020 How does the family, whose child is a client of DDD request access to the VPP? Parents must make a written request for voluntary out-of-home placement services (DSHS 10-277) for their child to their DDD case resource manage. The request is considered when the following criteria are met:

(1) The child is under eighteen years of age;

(2) The placement is due solely to the child's disability;

(3) The family is currently using some DDD services or is on the list for services;

(4) There are available funds for the VPP;

(5) There are no issues of abuse and neglect; and

(6) The custodial parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside outside of the parent's home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0020, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0025 What is the process for a child or youth who transfers from children's administration to get into the VPP? (1) At the regional level, a staffing occurs. It involves DDD and DCFS social workers and supervisors, and any other agency representatives who have knowledge of the child or youth's issues.

(2) At the staffing the participants discuss the criteria outlined in WAC 388-826-0010 and 388-826-0015.

(3) Within available resources and when appropriate criteria are met, social workers determine the appropriateness of the transfer of the child's case from one administration to the other.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0025, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0030 How is a decision made for out-of-home placement? A parent makes a written request for out-of-home placement, to her/his child's case manager. Prior to a decision for out-of-home placement, a staffing is held. The purpose of the staffing is to determine whether all other available and appropriate services have been used or could be used by the family. The parents, the DDD case manager, the DDD social worker, and/or resource developer and where appropriate, DCFS social worker may participate in staffings.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0030, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0035 How is a decision made regarding participation in the voluntary placement program? (1) A decision regarding participation in VPP is based on the premise that all available DDD services to the child and family have been used and that out-of-home placement is in the best interest of the child and that the placement is due solely to the child's disability;

(2) There are funds available in VPP;

(3) Through a staffing, the family's DDD case resource manager, VPP supervisor and VPP social worker, and any other person who can provide useful information, discuss the services used, and share information and resources regarding the needs of the family and child;

(4) DDD and the parents must be in agreement about the need for out-of-home placement and that the request fits the criteria for the program. When both parties are in agreement, a written voluntary placement agreement is signed by the parent and DDD representative:

(a) If there are no funds available, parents may sign a request for out-of-home placement (DSHS 10-277);

(b) When it is determined that the request is appropriate, the child or youth is eligible for out-of-home placement, there are available funds and there is a placement, the agreement is signed and the child's file is transferred to a DDD social worker in the voluntary placement program;

(c) If there are funds available, the consideration for out-of-home placement continues. The name of the child/youth is placed on the VPP data base for consideration of placement outside the home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0035, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0040 What is a voluntary placement agreement? It is a mutually voluntary and written document between the parent and the department. It must be signed by the child's parent and the DSHS/DDD representative to be in effect. An agreement regarding a Native American child is not valid unless executed in writing before the court and filed with the court as provided in RCW 13.34.130. Any party to the voluntary placement agreement may terminate the agreement at any time. When one party ends the agreement, per the VPA, the voluntary agreement is ended.

The agreement authorizes DSHS/DDD to facilitate a placement for the child who is under eighteen years of age in a licensed facility. Under the term of the agreement, the parent retains legal custody. DSHS/DDD is responsible for the child's placement and care. The agreement shall at a minimum specify the legal status of the child and the rights and obligations of the parent or legal guardian, the child, and the department while the child is in placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0040, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0045 What happens after a voluntary placement agreement is signed, what are the legal issues and who is responsible? When the DDD social worker facilitates the placement of a child in a licensed out-of-home care arrangement, under a DDD voluntary placement agreement, the department has the responsibility for the child's placement and care. The department shall:

(1) In conjunction with the parents, develop an individual services plan for the child no later than sixty days from the date that the department assumes responsibility for the child's placement and care;

(2) Develop a shared parenting plan with foster care providers and parents;

(3) Obtain a judicial determination, within one hundred eighty days of placement, in accordance with RCW 13.34.030 and 13.34.270 that the placement is in the best interest of the child;

(4) Attend the permanency planning hearing reviews where a review of the child's out-of-home placement determines if it continues to be in the best interest of the child to continue the out-of-home placement;

(5) Make a face-to-face visit with the child and visit with the child in their licensed placement, every ninety days;

(6) Facilitate a judicial review at one hundred eighty days and annually thereafter, unless the child's placement ends before one hundred eighty days have elapsed;

(7) Provide for periodic administrative reviews of the child's case, unless a judicial review occurs every one hundred eighty days after initial placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0045, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0050 Is there an ongoing court process when the child is in out-of-home placement and how does the process work? The ongoing court process involves the following activities:

(1) When a child is placed in a licensed out-of-home setting, within one hundred eighty days, the DDD social worker must file an order with the court that says the custodial and legal parent has signed a voluntary placement agreement with DDD and voluntarily requests placement of their child in out-of-home care;

(2) The child's DDD social worker prepares the necessary papers and files them with the court clerk; and

(3) Once a year, the DDD social worker prepares a report that must be presented to the court. It is called an order for continued placement and it describes in the words of the social worker, why the out-of-home placement continues to be in the best interest of the child.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0050, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0055 What basic services may a child receive from the voluntary placement program? (1) Shared parenting between foster care providers and parents on daily routines;

(2) Medical coverage, under a medical coupon issued from the foster care medical unit (FCMU);

(3) Coordination with special education services in the local school district when the child meets eligibility criteria;

(4) Supervised special activities in the community when appropriate;

(5) Safe, developmentally appropriate care;

(6) Supervision by a DDD social worker who has responsibility for visiting the child/youth at a minimum, every ninety days;

(7) An individual services plan for the child within sixty days from the date that DSHS/DDD assumes responsibility for the child's placement and care;

(8) DDD social worker prepares documents for court, and pursuant to RCW 13.34.030 and 13.34.270 shares the documents at the court hearings in order to determine that the placement is in the best interest of the child;

(9) Social work services such as needs assessment, referral, service coordination and case monitoring;

(10) Early intervention services: DDD ensures coordination of services for children from birth through thirty-five months of age with early intervention and special education; and

(11) Medically intensive services under WAC 388-531-3000.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0055, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0060 Are there other services a child may receive in this program? In-home supports may be available to support a child in the parent's home. Approval of in-home support services is based on available funds. The criteria to receive in-home supports when there are available funds are:

(1) Children whose current out of home placement disrupts and who are awaiting new out-of-home placements;

(2) Children whose names are on the data base and whose parents have signed a "request for out-of-home placement."

Service need level for in-home services are evaluated every six months and reviewed every ninety days thereafter. Any reduction in service or denial of services allows the child's family the right to appeal the decision under chapter 388-825 WAC.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0060, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0065 What can parents expect if they use in-home supports under this program? Within available funds, the child may sometimes receive supports. Supports may be in the form of respite services, specialized behavioral support, and other services that are needed to support the child's continued living arrangement in the parent's home. A person meeting provider qualifications may provide the supports to the child in the home, through a contract with DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0065, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0070 What is the responsibility of the department for the child who is in out-of-home care? When DDD facilitates an out-of-home placement, DDD is responsible for:

(1) A voluntary placement agreement according to this section;

(2) Monitoring of the child's placement and care;

(3) A permanency plan of care for the child;

(4) A plan that monitors the health, safety and appropriateness of the child's placement at a minimum every ninety days, making face-to-face visits at that time;

(5) The DDD social worker maintains any records as required by court oversight; and

(6) DDD social worker facilitates a needs assessment, individual service plan and a shared parenting plan.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0070, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0075 What are the responsibilities of the parents when their child receives services in the voluntary placement program? Parents retain custody of their child at all times when the child is receiving services in the voluntary placement program. Parents responsibilities include, but are not limited to, the following:

(1) The right to make all major nonemergency decision about medical care, enlistment in military service, marriage and other important legal decisions for the person under eighteen years of age;

(2) Maintain ongoing and regular contact with the child;

(3) Agree to work cooperatively with their child's DDD social worker and other DSHS staff and persons caring for their child;

(4) Participate in decision making for their child;

(5) Cooperate with DDD in selecting a representative payee for the child's Social Security benefits, received from the Social Security Administration, and which are used for basic maintenance while the child is in out-of-home care;

(6) Agree that if their child's out-of-home placement disrupts, their child will return to the parents physical care until a new placement is developed. The parent's signature on the voluntary placement agreement confirms their understanding of the responsibilities listed in the VPA.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0075, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0080 What are the expectations for parents when their child is in out-of-home care? Parents are expected to be active in the "shared parenting" plan and continue to be involved in their child's life. The plan is a written agreement between the licensed foster parents or provider caring for the child and the child's parents. It includes:

(1) Responsibilities of legal and foster parents or provider;

(2) Plan for respite;

(3) Emergency procedures;

(4) Planned activities;

(5) Expectations and special considerations; and

(6) Involvement on a regular basis by the parent.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0080, filed 10/31/02, effective 12/1/02.]

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 388-826-0090 What does a parent do with the child's Social Security benefits when the parent's child lives outside the parent's home? (1) When a parent signs a DDD VPA, the DDD social worker shares with the parent a list of representative payee agencies. From the list, parents must select a representative payee for their child's SSI benefits.

(2) Each month, the child's SSI check will be sent to the representative payee. The portion of the check designated for "room and board," the amount that is allowed for basic maintenance while in foster care and when parents are not caring for their child in their own home, is sent to the licensed foster care provider for reimbursement for basic maintenance.

(3) The representative payee sets aside an amount from the child's SSI warrants designated as "client personal incidentals or CPI" and it is entered into a trust account for the child or youth. It is made available for items that are of a direct benefit to the child. The representative payee monitors the account held in trust for the child and notifies the DDD

social worker when the account is within three hundred dollars of the maximum reserve exemption allowance.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0090, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0095 Who pays for a child's care when a child is in out-of-home placement? State funds, federal funds and the child's SSI, that is used for basic maintenance support the cost of the child's care while the child is in licensed out-of-home placement. The parent is encouraged to continue to support their child with typical activities, e.g., presents, clothing, special items, special outings. Licensed providers who care for the child in a licensed setting will be paid directly through a contract with DDD and according to an established rate structure, established within DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0095, 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	9999999

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 388-826-0150 What happens if the level assigned to the child changes? The care needs of all children in foster care will be reassessed annually or more often if a major life change occurs.

(1) A "major life change" is an unexpected, documented change in a child's medical or psychological condition that affects the level of care required.

(2) If the assessed level changes and results in a rate change, the foster parent will receive at least thirty days written notice of the rate change. The notice will include the date that the rate change takes effect.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0150, filed 1/31/06, effective 3/3/06.]

WAC 388-826-0160 What limitations exist on administrative hearings regarding foster care payments in VPP? The foster care provider and the parents are not entitled to request an administrative hearing to dispute the established foster care rates.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0160, filed 1/31/06, effective 3/3/06.]

WAC 388-826-0170 How are rates for licensed staffed residential homes determined in VPP? Rates for licensed staffed residential homes are determined by the department after review of the needs of the child, the proposal from the licensed staffed residential agency and the proposed staffing schedule.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0170, filed 1/31/06, effective 3/3/06.]

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.]

WAC 388-826-0200 What happens if the voluntary placement ends? The child must be returned to the physical care of the child's legal parent unless the child has been taken into custody pursuant to RCW 13.34.050 or 26.44.050, placed in shelter care pursuant to RCW 13.34.060, or placed in foster care pursuant to RCW 13.34.130. The agreement as described in RCW 74.13.350, between DDD and legal parents is completely voluntary. Per RCW 74.13.350, any party may terminate the agreement at any time.

[06-01-107, recodified as § 388-826-0200, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0100, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0210 When the child leaves the voluntary placement program for any reason, what DDD services are available to the child and family when voluntary placement ends? Depending on availability of funds, the child and family may be eligible for other DDD programs and that would support the child.

[06-01-107, recodified as § 388-826-0210, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0105, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0220 Will a child or youth continue to receive special education or early intervention services while in VPP? (1) Early intervention services are available to a child, birth through thirty-five months when in VPP and when that child meets the early intervention eligibility criteria.

(2) When a child or youth meets eligibility criteria for special education programs, ages three to twenty-one years, the child or youth continues to receive special education services through their local public school district.

(3) Office of superintendent of public instruction is responsible for the special education program for the eligible children, ages three to twenty-one years, RCW 28A.155.220 allows that children and youth who meet eligibility criteria may remain in special education until graduation, if that occurs during the school year.

[06-01-107, recodified as § 388-826-0220, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0110, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0230 What happens after a youth turns eighteen? When a youth turns eighteen, and is considered an adult, while in the voluntary placement program, the youth may remain in the child foster home, in VPP, under the following circumstances:

(1) Youth remains in the education or vocational program in the local public school district in which he/she has been enrolled until graduation or age twenty-one, whichever is earlier, per WAC 392-172-030(2), RCW 74.13.031 (10) and (13), 28A.155.020, and 28A.155.030;

(2) The placement remains intact and does not disrupt;

(3) When needed, youth who turns eighteen can self-administer medication;

(4) Youth cannot remain in foster care, living in a child foster home, and in VPP, after eighteen years of age when:

(a) The child foster home placement disrupts;

(b) The youth leaves education or vocational program; or

(c) The youth who turns eighteen needs someone to administer medication.

Dependency guardianships end at age eighteen. If a youth has been in a legal guardianship, under chapter 11.88 RCW and if the reason for guardianship was the minority of the child the guardianship ends.

[06-01-107, recodified as § 388-826-0230, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0115, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0240 What happens if a parent disagrees with a decision made by DDD? If a parent disagrees with a decision made by DDD staff, the parent has the right to pursue the appeal process, as outlined in RCW 71A.10.050 and chapter 388-02 WAC.

[06-01-107, recodified as § 388-826-0240, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0120, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0250 Does DDD make exceptions to the requirements in this chapter? DDD may grant exceptions to the requirements specified in this chapter as long as the DDD director approves the request in writing within sixty days.

[06-01-107, recodified as § 388-826-0250, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0125, filed 10/31/02, effective 12/1/02.]

Chapter 388-827 WAC
STATE SUPPLEMENTARY PAYMENT PROGRAM

WAC

WAC 388-827-0100 What is the state supplementary payment (SSP) that is administered by the division of developmental disabilities (DDD)? The state supplementary payment (SSP) is a state-paid cash assistance program for certain clients of the division of developmental disabilities.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0100, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0105 What are the eligibility requirements for the DDD/SSP program? To be eligible to receive DDD/SSP, you must be determined DDD eligible under RCW 71A.10.020 and meet all of the financial and programmatic criteria for DDD/SSP.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0105, filed 12/29/03, effective 1/29/04.]

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 388-827-0120 How often will my eligibility for DDD/SSP be redetermined? Redetermination of eligibility for the DDD/SSP program will be conducted at least every twelve months, or more frequently if deemed necessary by DDD.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0120, 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 388-827-0130 Can I choose not to accept DDD/SSP payments? If your service funding has been converted to the DDD/SSP program, DDD/SSP payments are the only way you can receive that funding.

(1) If you choose not to receive DDD/SSP payments, you will not receive department funding for that service.

(2) Your home and community based services (HCBS) waiver service(s) administered by DDD but not funded by DDD/SSP payments will not be affected by your choice to receive or reject DDD/SSP payments.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0130, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0131 What happens if I no longer meet the financial or programmatic requirements after my funding has been converted to the DDD/SSP program? If you no longer meet the eligibility requirements in WAC 388-827-0105, 388-827-0110, or 388-827-0115, you may continue to receive services only if an exception to the rules is approved in accordance with WAC 388-827-0300.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0131, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0135 Can I apply for the DDD/SSP program if I am not identified by DDD as eligible for the DDD/SSP program? You can apply through your case resource manager to determine eligibility for SSP but eligibility is limited to those meeting the eligibility requirements in WAC 388-827-0105, 388-827-0110, and 388-827-0115.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0135, 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 388-827-0145 How much money will I receive? The purpose of the SSP is to increase the amount of income to meet your needs. The department will determine your payment amount based on your living arrangement and your assessed needs.

(1) For residential and voluntary placement program services, the amount of your SSP will be based on the amount of state-only dollars spent on certain services at the time the funding source was converted to SSP. If the type of your residential living arrangement changes, your need will be reassessed and your payment adjusted based on your new living arrangement and assessed need.

(2) For family support services, refer to WAC 388-825-200 through 388-825-256.

(a) If you are on the home and community based services (HCBS) waiver administered by DDD:

(i) You will receive nine hundred dollars DDD/SSP money per year to use as you determine.

(ii) The remainder up to the maximum yearly award for traditional family support or family support opportunities may be authorized by DDD to purchase HCBS waiver services and will be paid directly to the provider.

(b) If you are not on the HCBS waiver administered by DDD, and you received state-only funding for the traditional family support program between March 1, 2001 and June 30, 2003 the amount of your SSP will be based on the yearly maximum allowed at the time the funding source was converted to SSP unless your need changes.

(i) Need is based on your service need level and whether you receive medicaid personal care as specified in WAC 388-825-254.

(ii) If your need changes, the amount of your SSP will be adjusted accordingly.

(c) If you are not on the HCBS waiver administered by DDD, and you received state-only funding for the family support opportunity program between March 1, 2001 and June 30, 2003 the amount of your SSP will be fifteen hundred dollars per year.

(d) The yearly amount of DDD/SSP money will be prorated into monthly amounts. You will receive one twelfth of the yearly amount each month.

(3) If you are eligible for SSP because you meet the criteria in WAC 388-827-0115(5), you will receive one hundred dollars per month.

(4) DDD may authorize additional payments to certain individuals if the SSP budget has sufficient funds to allow this payment.

[Statutory Authority: RCW 71A.12.030, 74.04.057 and 20 C.F.R. 416.2099. 06-24-074, § 388-827-0145, 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, § 388-827-0145, filed 4/28/05, effective 5/29/05. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0145, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0146 May I voluntarily remove myself from the home and community based services (HCBS) waiver administered by DDD in order to increase the amount of my SSP? You may voluntarily remove yourself from the HCBS waiver administered by DDD but your SSP will not increase because of this action.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0146, 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.]

WAC 388-827-0155 Who will the warrant/check be sent to? (1) If you are a child under the age of eighteen, the warrant/check will be sent to your legal representative or protective payee or representative payee.

(2) If you are a person age eighteen and older, the warrant/check will be sent directly to your protective payee or representative payee if you have one.

(3) If you do not have a protective payee or representative payee, the warrant/check will be sent directly to you.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0155, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0160 How will the warrant/check be sent? You may choose to have your check delivered through the U.S. Postal Service, or as an electronic funds transfer.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0160, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0170 Are there rules restricting how I use my DDD/SSP money? There are no restrictions on how you use your DDD/SSP money.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0170, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0175 What changes must I report to the department? You must report changes in your circumstances within ten days from the date you become aware of the change. You must tell us if:

(1) Your SSI stops and you became ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) Your address changes; or

(3) There is a change in your living arrangement that affects your assessed need.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0175, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0175, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0180 Do I have additional responsibilities when I purchase my own services? (1) When you use DDD/SSP funds paid directly to you to purchase in-home services from individuals, you become the employer. As the employer, you may have tax liabilities. If you have questions regarding employer tax issues, you can contact the Internal Revenue Service.

(2) If you want to obtain a criminal background check of any employee who will have unsupervised access to children or adults with developmental disabilities, you may get the background check done through the Washington State Patrol. You can ask your DDD case resource manager to assist you with completing these background checks.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0180, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0185 When will the department stop sending my DDD/SSP money? The department will stop sending your DDD/SSP money when:

(1) You no longer are eligible for or receive SSI cash benefits and are ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) You no longer demonstrate a need for the services as described in WAC 388-827-0115; or

(3) Your DDD eligibility is terminated.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0185, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0185, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0200 What is a representative payee? A representative payee is a person, organization, institution or agency that manages your DDD/SSP. They may also provide services such as helping you manage your money.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0200, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0210 Who can be a representative payee for my DDD/SSP? (1) A representative payee may be:

(a) The person, organization, institution or agency that acts as your representative payee for Supplemental Security Income (SSI);

(b) Your parent, if you are under eighteen;

(c) Your spouse; or

(d) A person, organization, institution or agency you select if the department approves your selection.

(2) If you select a representative payee under subsection (1) (d) of this section, the department will evaluate the selection according to the following criteria:

(a) The relationship of the payee to you;

(b) The amount of interest the payee shows in you;

(c) Any legal authority the payee has to act on your behalf;

(d) Whether the payee has custody of you; and

(e) Whether the payee is in a position to know of and look after your needs.

(3) The DDD director or designee will approve or deny your request for a representative under subsection (1)(d) of this section.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0210, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0215 What are the responsibilities of a representative payee? A representative payee has the responsibility to:

(1) Spend the DDD/SSP on you or your behalf;

(2) Notify the department if any event happens that may affect the amount of benefits you receive;

(3) Submit to the department, upon our request, a written report accounting for the payments received; and

(4) Notify the department of any change in the payee's circumstances that would affect performance of the payee responsibilities.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0215, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0300 Does DSHS make exceptions to the requirements in this chapter? DSHS may grant exceptions to the requirements specified in this chapter as long as the following conditions are met:

(1) You or your case manager may request an exception to a rule in this chapter.

(2) The case manager must submit a written request for an exception to his or her DDD regional administrator.

(3) DSHS will evaluate requests for exceptions, considering:

(a) The federal and state rules governing SSP; and

(b) The impact on the client if the exception is not approved.

(4) The DDD regional administrator will forward the request to the DDD director together with the regional administrator's recommendation to approve or deny the request.

(5) The DDD director or designee will approve or deny the request in writing within sixty calendar days after receiving the request from the case manager.

(6) The department will notify you of the decision.

(7) You do not have rights to adjudicative proceedings when you receive a denial from DSHS for an exception to the rules in this chapter.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0300, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0400 What is an SSP overpayment? (1) An overpayment means any SSP paid that is more than the amount you were eligible to receive.

(2) If you request a hearing and the hearing decision determines that you received any DDD/SSP money that you were not eligible to receive, then some or all of the DDD/SSP you received before the hearing decision must be paid back to the department.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0400, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0410 When can an overpayment occur? An overpayment can occur when:

(1) You were not eligible for and did not receive supplemental security income in the month in which the SSP was issued and were ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) You were no longer eligible for services from the division of developmental disabilities in the month in which the SSP was issued; or

(3) Your assessed need has changed.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0410, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0410, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0420 Who is liable for repayment of an overpayment? (1) If you received the money in your own name, you are responsible for repayment.

(2) If you are paid through a representative payee, both you and the representative payee may be responsible for repayment.

(a) You are responsible to the extent that the incorrect payments were spent on you or your behalf. Funds conserved by a representative payee to which you do not have direct access have not been spent on you or your behalf.

(b) If the incorrect payments were spent on you or your behalf and the representative payee is without fault in connection with the overpayment, you are solely responsible for repayment.

(c) The representative payee is solely responsible for repayment if:

(i) The incorrect payments were not spent on you or your behalf; and

(ii) The representative payee is at fault in connection with the overpayment.

(d) A government entity or an institution can be a representative payee and can be found responsible for repayment, just as a private individual can.

(e) You and the representative payee are both responsible for repayment when the incorrect payments have been spent on you or your behalf and the representative payee is at fault.

(3) The representative payee is at fault when the representative payee was aware of the reason you were not eligible for the SSP.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0420, filed 12/29/03, effective 1/29/04.]

Chapter 388-828 WAC

THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) ASSESSMENT

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10380, filed 5/30/08, effective 7/1/08.] Decodified by 08-15-091, filed 7/17/08, effective 7/17/08. Recodified as WAC 388-828-9700.

388-828-1240 What does DDD do when family income and household dependent information are not provided? [Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1240, filed 4/23/07, effective 6/1/07.] Repealed by 08-12-037, filed 5/30/08, effective 7/1/08. Statutory Authority: RCW 71A.12.30 [71A.12.-030] and Title 71A RCW.

388-828-1260 What action will DDD take if your family does not report income and dependent information? [Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1260, filed 4/23/07, effective 6/1/07.] Repealed by 08-12-037, filed 5/30/08, effective 7/1/08. Statutory Authority: RCW 71A.12.30 [71A.12.-030] and Title 71A RCW.

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? [Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-10-029, § 388-828-1280, filed 4/23/07, effective 6/1/07.] Repealed by 08-12-037, filed 5/30/08, effective 7/1/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW.

PURPOSE AND SCOPE

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.]

DEFINITIONS

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.]

DIVISION OF DEVELOPMENTAL DISABILITIES ASSESSMENT

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;

(d) Supported living residential services per chapter 388-101 WAC;

(e) Group home residential services per chapter 388-101 WAC;

(f) Group training home residential services per chapter 388-101 WAC;

(g) Companion home residential services per chapter 388-829C WAC; or

(h) Individual and family services per chapter 388-832 WAC.

(4) Records your service requests.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1060, filed 5/30/08, effective 7/1/08; 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 specific 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 Who does DDD ask to disclose financial information? When administering the DDD assessment, DDD is required to ask for annual gross income information from:

(1) Your family, if:

(a) You are age seventeen or younger; and

(b) Your family has not made a request for your admission to a residential habilitation center (RHC); or

(2) You, if:

(a) You are age eighteen or older; and

(b) You are receiving state-only funded services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1200, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-1200, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1220 Will DDD require the reported annual gross income to be verified with supporting documentation? DDD accepts a verbal report of annual gross income and does not require supporting documentation to verify the reported information.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1220, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-1220, filed 4/23/07, effective 6/1/07.]

WAC 388-828-1300 How will your access to, or receipt of, DDD paid services, private duty nursing services, or SSP be affected if income information is not reported? Your access to, or receipt of, DDD paid services per WAC 388-828-1440, 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 income information is not reported.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1300, filed 5/30/08, effective 7/1/08; 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.

[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 2009, 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; or

(2) Emergency services as determined by DDD as critical to the client's health and safety.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1480, filed 5/30/08, effective 7/1/08; 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 a DDD employee 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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1540, filed 5/30/08, effective 7/1/08; 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
(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

	Client Group			
DDD Assessment Panel Name	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

	Client Group			
DDD Assessment Panel Name	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

	Client Group			
DDD Assessment Panel Name	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, BH, 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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-1640, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-1640, filed 4/23/07, effective 6/1/07.]

SUPPORT ASSESSMENT MODULE

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

Components contained in the Support Assessment module	Age (0-15)	Age (16+)
DDD Activities of Daily Living Acuity Scale	Yes	Yes
DDD Behavioral Acuity Scale	Yes	Yes
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.]

THE SUPPORT ASSESSMENT FOR CHILDREN

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

Answers	Definitions	LOC Score	Acuity Score
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

Answers	Definitions	LOC Score	Acuity Score
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
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
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
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.]

THE SUPPORTS INTENSITY SCALE ASSESSMENT

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:

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
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	
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	

#	Lifelong Learning Activities	Type of Support					Frequency of Support					Daily Support Time					Raw Score
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	
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
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
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
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	
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
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

#	Medical Supports Needed	No Support Needed	Some Support Needed	Extensive Support Needed
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
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:						
Home Living	Community Living	Lifelong Learning	Employment Support	Health and Safety	Social Activities	Then your percentile rank for the SIS subscale is:
						>99
>88	>94					>99

If your raw score for the following SIS subscale is:						
Home Living	Community Living	Lifelong Learning	Employment Support	Health and Safety	Social Activities	Then your percentile rank for the SIS subscale is:
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
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.]

DDD PROTECTIVE SUPERVISION ACUITY SCALE

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:

(a) The amount of waiver respite, if any, that you are authorized to receive;

(b) Your individual and family services level, if you are authorized to receive individual and family services per chapter 388-832 WAC; and

(c) Your residential service level of support, if you are authorized to receive a residential service listed in WAC 388-828-10020 [WAC 388-828-9510].

(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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5020, filed 5/30/08, effective 7/1/08; 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

Answers	Definitions	Score
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.
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 2 from your level of monitoring score
12-15 years of age	Subtract 3 from your level of monitoring score
8-11 years of age	Subtract 4 from your level of monitoring score
5-7 years of age	Subtract 5 from your level of monitoring score
0-4 years of age	Subtract 6 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 three. For age twelve through fifteen, this equals an adjusted protective supervision score of one.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5080, filed 5/30/08, effective 7/1/08; 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
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.]

DDD Caregiver Status Acuity Scale

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:

(a) The amount of waiver respite, if any, that you are authorized to receive; and

(b) Your individual and family services level, if you are authorized to receive individual and family services.

(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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5140, filed 5/30/08, effective 7/1/08; 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
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.]

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

If the following criteria are met:	Then your caregiver risk factor (s) are:
(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
(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.	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 Caregiver 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 backup caregiver is:	Then your risk level score 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.	1 (Not at risk)
(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; or (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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5360, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-5360, filed 4/23/07, effective 6/1/07.]

DDD ACTIVITIES OF DAILY LIVING (ADL) ACUITY SCALE

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.]

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:
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
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.]

DDD BEHAVIORAL ACUITY SCALE

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:

(a) The amount of waiver respite, if any, that you are authorized to receive;

(b) Your individual and family services level, if you are authorized to receive individual and family services per chapter 388-832 WAC; and

(c) Your residential service level of support, if you are authorized to receive a residential service listed in WAC 388-828-10020 [WAC 388-828-9510].

(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.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5520, filed 5/30/08, effective 7/1/08; 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
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
	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

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:
Frequent	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.]

DDD MEDICAL ACUITY SCALE

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.]

DDD INTERPERSONAL SUPPORT ACUITY SCALE

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?
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?

Interpersonal support needs questions from the support assessment for children in WAC 388-828-3040	
Question #	Text of Questions:
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
(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
(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.]

DDD MOBILITY ACUITY SCALE

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 determined 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.]

RESPITE ASSESSMENT

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 388-829C WAC.

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-5940, filed 5/30/08, effective 7/1/08; 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

If your Protective Supervision Support Level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your respite assessment level is:
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
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

If your Protective Supervision Support Level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your respite assessment level is:
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
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

If your Protective Supervision Support Level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your respite assessment level is:
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
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

If your Protective Supervision Support Level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your respite assessment level is:
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
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.]

PROGRAMS AND SERVICES COMPONENT

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.]

SERVICE LEVEL ASSESSMENT MODULE

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.]

DDD SEIZURE ACUITY SCALE

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
(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.]

INDIVIDUAL SUPPORT PLAN MODULE

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 following components of the individual support plan module determine a service level and/or number of hours:

(1) The foster care rate assessment, as defined in chapter 388-826 WAC;

(2) The individual and family services algorithm, as defined in WAC 388-828-9000 through 388-828-9140; and

(3) The residential algorithm, as defined in WAC 388-828-10000 [WAC 388-828-9500] through 388-828-10380 [388-828-9700].

[Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-8020, filed 5/30/08, effective 7/1/08; 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

#	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
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
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	
B8	Accessing public buildings and settings	2 or more	

#	SIS Activity	DDD must address in the ISP if your Type of Support score is:	Health and Welfare Category
D3	Interacting with co-workers	3 or more	Employment
D4	Interacting with supervisors and or coaches	3 or more	
E1	Taking medications	2 or more	Health and Safety
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	
E7	Maintaining physical health and fitness	3 or more	
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.]

INDIVIDUAL AND FAMILY SERVICES ASSESSMENT

WAC 388-828-9000 What is the individual and family services assessment? The individual and family services assessment is an algorithm in the DDD assessment that determines an award amount that you may receive if DDD has authorized you to receive individual and family services per chapter 388-832 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9000, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9020 What is the purpose of the individual and family services assessment? The purpose of the individual and family services assessment is to determine your individual and family services level and score using your assessed support levels from:

(1) The DDD protective supervision acuity scale (See WAC 388-828-5000 to 388-828-5100);

(2) The DDD caregiver status acuity scale (See WAC 388-828-5120 to 388-828-5360);

(3) The DDD behavioral acuity scale; (See WAC 388-828-5500 to 388-828-5640);

(4) The DDD medical acuity scale; (See WAC 388-828-5660 to 388-828-5700); and

(5) The DDD activities of daily living (ADL) acuity scale (See WAC 388-828-5380 to 388-828-5480).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9020, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9040 How does DDD determine your individual and family services level? (1) DDD determines your individual and family services 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 individual and family services 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

If your protective supervision support level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your individual and family services level is:
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
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

If your protective supervision support level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your individual and family services level is:
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
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

If your protective supervision support level is:	And your primary care-giver risk level is:	And your backup care-giver risk score is:	And your behavioral acuity level is:	Then your individual and family services level is:
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
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

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 individual and family services level is:
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
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 individual and family services level when your individual and family services level is determined to be:

(a) Level one, two, three, or four; and

(b) 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, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9040, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9060 How does DDD determine your individual and family services rating? (1) Your individual and family services rating is determined by using the following table:

If your individual and family services level is:	Then your individual and family services support rating is:
1	0
2	240
3	336
4	432
5	528

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9060, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9100 How does DDD determine the number to use in the adjustment of your individual and family services support rating? DDD determines the amount of the adjustment for your individual and family services support rating using the following tables:

(1)

If your individual and family services level is 1, 2, 3, 4, or 5 and you are not eligible for medicaid personal care		And your ADL support needs level for the SIS per WAC 388-828-5480			
		None	Low	Medium	High
And your medical acuity level per WAC 388-828-5700	None	57	57	76	85
	Low	57	57	76	85
	Medium	57	88	122	145
	High	57	145	245	287

(2)

If your individual and family services level is 1, 2, 3, 4, or 5 and you are eligible for medicaid personal care per chapter 388-106 WAC		And your ADL support needs level for the SIS per WAC 388-828-5480			
		None	Low	Medium	High
And your medical acuity level per WAC 388-828-5700	None	0	0	0	0
	Low	0	0	0	0
	Medium	0	0	0	0
	High	0	0	0	0

Example: If your individual and family service level is 3 and you are not eligible for medicaid personal care services and your ADL support needs level is "low" and your medical acuity level is "medium," the amount of your adjustment is 88.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9100, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9120 How does DDD determine your individual and family services score? DDD adds your individual and family support rating from WAC 388-828-9060 to the adjustment amount in WAC 388-828-9100 to determine your individual and family services score.

Example: If you are not eligible for medicaid personal care services and your individual and family services support rating is 336 and the amount of your adjustment is 122, your individual and family services score is 458.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9120, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9140 How does DDD determine the amount of your individual and family service award? DDD uses the following table to determine the amount of your individual and family services award:

If your individual and family services score is:	Then the amount of your award is up to:
0 to 60	No Award
61 to 240	$2000
241 to 336	$3000
337 to 527	$4000
528 or more	$6000

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9140, filed 8/5/08, effective 9/5/08.]

RESIDENTIAL ALGORITHM

WAC 388-828-9500 What is the residential algorithm? The residential algorithm is a formula in the DDD assessment that determines the level of residential services and supports you may expect to receive based on your assessed support needs.

[08-15-091, recodified as § 388-828-9500, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10000, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9510 When is the residential algorithm administered? The residential algorithm must be administered when you are approved to receive one of the following paid services:

(1) Supported living residential services per chapter 388-101 WAC;

(2) Group home residential services per chapter 388-101 WAC;

(3) Group training home services per chapter 388-101 WAC; or

(4) Companion home residential services per chapter 388-829C WAC.

[08-15-091, recodified as § 388-828-9510, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10020, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9520 Where does the residential algorithm obtain your support needs information? The residential algorithm obtains your support needs information from the following components of your current DDD assessment:

(1) The supports intensity scale assessment (SIS) per WAC 388-828-4000 through 388-828-4320;

(2) The DDD protective supervision acuity scale per WAC 388-828-5000 through 388-828-5100;

(3) The DDD behavioral acuity scale per WAC 388-828-5500 through 388-828-5640;

(4) The DDD medical acuity scale per WAC 388-828-5660 through 388-828-5700;

(5) The program and services panel per WAC 388-828-6020;

(6) The DDD seizure acuity scale per WAC 388-828-7040 through 388-828-7080; and

(7) The DDD sleep panel per WAC 388-828-10260 [WAC 388-828-9640].

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WAC 388-828-9530 How does the residential algorithm identify your residential support needs score? The residential algorithm uses the support needs information from your current DDD assessment to identify the following residential support needs scores:

(1) Community protection program enrollment as defined in WAC 388-828-10100 [WAC 388-828-9590];

(2) Daily support needs score as defined in WAC 388-828-10120 [388-828-9560];

(3) Mid-frequency support needs score as defined in WAC 388-828-10140 [WAC 388-828-9580];

(4) Behavior support needs score as defined in WAC 388-828-10160 [WAC 388-828-9530];

(5) Medical support needs score as defined in WAC 388-828-10180 [WAC 388-828-9600];

(6) Seizure support needs score as defined in WAC 388-828-10200 [WAC 388-828-9610];

(7) Protective supervision support needs score as defined in WAC 388-828-10220 [WAC 388-828-9620];

(8) Ability to seek help score as defined in WAC 388-828-10240 [WAC 388-828-9630];

(9) Nighttime support needs score as defined in WAC 388-828-10260 [WAC 388-828-9640];

(10) Toileting support needs score as defined in WAC 388-828-10280 [WAC 388-828-9650]; and

(11) Total critical support time as defined in WAC 388-828-10300 [WAC 388-828-9660] through 388-828-10360 [388-828-9690].

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WAC 388-828-9540 What residential service levels of support does DDD use? DDD uses the following residential service levels of support which correspond with your assessed support needs (see WAC 388-828-10060 [WAC 388-828-9530]):

Support Need Level	Typical Support Need Characteristics from the DDD Assessment	Expected Level of Support*
Weekly or less Support Level 1	Client requires supervision, training, or physical assistance in areas that typically occur weekly or less often, such as shopping, paying bills, or medical appointments. Client is generally independent in support areas that typically occur daily or every couple of days.	Clients assessed to need this level receive support on a weekly basis or less frequently.
Multiple times per week Support Level 2	Client is able to maintain health and safety for a full day or more at a time AND needs supervision, training, or physical assistance with tasks that typically occur every few days, such as light housekeeping, menu planning, or guidance and support with relationships. Client is generally independent in support areas that must occur daily.	Clients assessed to need this level receive support multiple times per week.
Intermittent daily - Low Support Level 3A	Client is able to maintain health and safety for short periods of time (i.e., hours, but not days) OR needs supervision, training, or physical assistance with activities that typically occur daily, such as bathing, dressing, or taking medications.	Clients assessed to need this level receive daily support.
Intermittent daily -Moderate Support Level 3B	Client requires supervision, training, or physical assistance with multiple tasks that typically occur daily OR requires frequent checks for health and safety or due to disruptions in routines.	Clients assessed to need this level receive daily support and may receive checks during nighttime hours as needed.
Close proximity Support Level 4	Client requires support with a large number of activities that typically occur daily OR is able to maintain health and safety for very short periods of time (i.e., less than 2 hours, if at all) AND requires occasional health and safety checks or support during overnight hours.	Clients assessed to need this level receive supports in close proximity 24 hours per day. Support hours may be shared with neighboring households.

Support Need Level	Typical Support Need Characteristics from the DDD Assessment	Expected Level of Support*
Continuous day and continuous night Support Level 5	Client is generally unable to maintain health and safety OR requires support with a large number of activities that occur daily or almost every day AND requires nighttime staff typically within the household.	Clients assessed to need this level receive support 24 hours per day.
Community Protection Support Level 6	Client is enrolled in the community protection program.	Clients assessed to need this level of support will receive 24 hour per day supervision per community protection program policy.
*Emergency access to residential staff is available to all clients, 24-hours per day, regardless of the residential service level of support the assessment indicates.		

[08-15-091, recodified as § 388-828-9540, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10080, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9550 How does the residential algorithm determine if you are enrolled in the community protection program? The residential algorithm determines that you are enrolled in the community protection program if your current DDD assessment (see WAC 388-828-6020) shows that you are:

(1) On the community protection waiver; or

(2) Considered for the community protection waiver.

[08-15-091, recodified as § 388-828-9550, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10100, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9560 How does the residential algorithm determine your daily support needs score? The residential algorithm determines that you have daily support needs if you meet or exceed all of the qualifying scores for one or more of the following activities from the SIS:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)			
SIS Activity	If your score for type of support is:	And your score for frequency of support is:	And your daily support time is:
A1: Using the toilet	2 or more	3 or more	1 or more
A4: Eating food	2 or more	3 or more	1 or more
A6: Dressing	2 or more	3 or more	1 or more
A7: Bathing, personal hygiene, grooming	2 or more	3 or more	1 or more
A9: Using currently prescribed equipment or treatments	2 or more	3 or more	1 or more
E1: Taking medication	2 or more	3 or more	1 or more
E2: Avoiding health and safety hazards	1 or more	3 or more	1 or more
E4: Ambulating and moving about	3 or more	3 or more	1 or more
Or			
Any combination of 3 of the SIS activities listed above (A1, A4, A6, A7, A9, E1, E2, E4)	1 or more	3 or more	1 or more

[08-15-091, recodified as § 388-828-9560, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10120, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9570 How does DDD define mid-frequency support? DDD defines mid-frequency support as support for selected SIS activities that most people perform every two to four days.

[08-15-091, recodified as § 388-828-9570, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10130, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9580 How does the residential algorithm determine your mid-frequency support needs score? The residential algorithm determines that you have mid-frequency support needs if you meet one of the following three conditions:

(1) You meet or exceed all of the qualifying scores for one or more of the following activities from the SIS assessment:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)			
SIS Activity	If your type of support score is:	And your frequency of support score is:	And your daily support time score is:
A3: Preparing food	2 or more	2 or more	2 or more
A5: Housekeeping and cleaning	3 or more	3 or more	2 or more
B2: Participating in recreational/leisure activities in community settings	3 or more	2 or more	2 or more
B7: Interacting with community members	3 or more	2 or more	2 or more
G3: Protecting self from exploitation	2 or more	2 or more	2 or more

(2) Or you meet or exceed all of the qualifying scores for four or more of the following activities from the SIS assessment:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)				
SIS Activity	If your type of support score is:	And your frequency of support score is:	And your daily support time score is:	Score if you meet or exceed criteria
A1: Using the toilet	1 or more	2 or more	1 or more	
A3: Preparing food	1 or more	2 or more	1 or more	
A4: Eating food	1 or more	2 or more	1 or more	
A5: Housekeeping and cleaning	1 or more	2 or more	1 or more	
A6: Dressing	1 or more	2 or more	1 or more	
A7: Bathing, personal hygiene and grooming	1 or more	2 or more	1 or more	
A9: Using currently prescribed equipment and medications	1 or more	2 or more	1 or more	
B2: Participating in recreational/leisure activities in community settings	1 or more	2 or more	1 or more	
B7: Interacting with community members	1 or more	2 or more	1 or more	
E1: Taking medications	1 or more	2 or more	1 or more	
E2: Avoiding health and safety hazards	1 or more	2 or more	1 or more	
E4: Ambulating and moving about	1 or more	2 or more	1 or more	
G3: Protecting self from exploitation	1 or more	2 or more	1 or more	
			Total of all questions where criteria is met or exceed =	Sum of scores entered

(3) Or you meet the qualifying scores for the following SIS activities and your total weekly critical support time score exceeds ten hours:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)					
SIS Activity	If your type of support score is:	And your frequency of support score is:	And your daily support time score is:	Your weekly critical support time is:	Enter one time for each qualifying SIS activity
A2: Taking care of clothes (includes laundering)	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

B3: Using public services in the community	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
B6: Shopping and purchasing foods and services	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
F2: Participation in recreational / leisure activities with others	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
F8: Engaging in volunteer work	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
G2: Managing money and personal finances	1 or more	2 or more	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
Mid-frequency support needs weekly critical support time total =					Sum of times entered

[08-15-091, recodified as § 388-828-9580, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10140, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9590 How does the residential algorithm determine your behavior support needs score? The residential algorithm uses your behavioral acuity level from the behavioral acuity scale, per WAC 388-828-5500 through 388-828-5640, to determine your behavior support needs score.

[08-15-091, recodified as § 388-828-9590, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10160, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9600 How does the residential algorithm determine your medical support needs score? The residential algorithm uses your medical acuity level from the medical acuity scale, per WAC 388-828-5660 through 388-828-5700, to determine your medical support needs score.

[08-15-091, recodified as § 388-828-9600, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10180, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9610 How does the residential algorithm determine your seizure support needs score? The residential algorithm uses your seizure acuity level from the seizure acuity scale, per WAC 388-828-7040 through 388-828-7080, to determine your seizure support needs score.

[08-15-091, recodified as § 388-828-9610, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10200, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9620 How does the residential algorithm determine your protective supervision support needs score? The residential algorithm uses your adjusted protective supervision score from the protective supervision acuity scale, per WAC 388-828-5000 through 388-828-5100, to determine your protective supervision support needs score.

[08-15-091, recodified as § 388-828-9620, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10220, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9630 How does the residential algorithm determine your ability to seek help score? The residential algorithm determines your ability to seek help score by using your answer to the following question found in the protective supervision acuity scale (WAC 388-828-5060(3)).

Protective Supervision Acuity Scale Question:	If your answer to the following question is:	Then your ability to seek help score is:
Is client able to summon help?	Can call someone who is remote	Yes
	Can seek help outside the house, nearby	Yes
	Can seek help inside house	No
	Cannot summon help	No

[08-15-091, recodified as § 388-828-9630, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10240, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9640 How does the residential algorithm determine your nighttime support needs score? The residential algorithm scores the answers to each of the five following questions from the DDD sleep panel in the service level assessment to determine your nighttime support needs:

(1)

DDD Sleep Panel Question	If you answer to the question is:	Then your support needs score for this question is:
Nighttime Assistance*needed? Frequency	0 = None or less than monthly	Less than daily
	1 = At least once a month but not once a week	Less than daily
	2 = At least once a week but not once a day	Less than daily
	3 = At least once a day but not once an hour	Daily or more frequently
	4 = Hourly or more frequently	Daily or more frequently
* Nighttime assistance needed means that the person wakes in the night and requires assistance with toileting, mobility, medical issues, behaviors, guidance through sleepwalking, or other support requiring intervention.		

(2)

DDD Sleep Panel Question	If your answer to this question is:	Then your support needs score for this question is:
Nighttime assistance needed? Daily support time	0 = None	Less than (<) 30 minutes
	1 = Less than 30 minutes	Less than (<) 30 minutes
	2 = 30 minutes to less than 2 hours	30 minutes or more
	3 = 2 hours to less than 4 hours	30 minutes or more
	4 = 4 hours or more	30 minutes or more

(3)

DDD Sleep Panel Question	If your answer to this question is:	Then your support needs score for this question is:
Can toilet self at night?	Yes	Yes
	No	No

(4)

DDD Sleep Panel Question	If your answer to this question is:	Then your support needs score for this question is:
Wakes to toilet most nights?	Yes	Yes
	No	No

(5)

DDD Sleep Panel Question	If your answer to this question is:		Then your support needs score for this question is:
Nighttime behavioral/anxiety issues?	None	Defined as: No behavioral or anxiety issues at night.	No
	Minor	Defined as: You experience low to medium behavioral or anxiety issues when left alone at night, but can manage the behaviors/anxiety with minimal or no intervention.	No
	Moderate	Defined as: You experience intense behavioral or anxiety issues when left alone at night, but you are managing to cope, even if only minimally, by yourself or with remote or occasional onsite help as needed.	No
	Severe	Defined as: You experience intense behavioral or anxiety issues on most nights if left alone and require a support person within your home during all overnight hours in	Yes

DDD Sleep Panel Question	If your answer to this question is:		Then your support needs score for this question is:
		order to maintain yours and/or other's health and safety.	

[08-15-091, recodified as § 388-828-9640, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10260, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9650 How does the residential algorithm determine your toileting support needs score? The residential algorithm adds the three dimensions of the SIS activity "A1: Using the toilet" (see WAC 388-828-4200) to determine your toileting support score. Formula:

Type of support score (0-4)
+
Frequency of support score (0-4)
+
Daily support time score (0-4)
=
Toileting support needs score (0-12)

[08-15-091, recodified as § 388-828-9650, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10280, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9660 How does the residential algorithm calculate your daily critical support time? The residential algorithm uses the following chart to calculate your daily critical support time score:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)					
SIS activity:	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
A1: Using the toilet	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A4: Eating food	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A6: Dressing	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

SIS activity:	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A7: Bathing and taking care of personal hygiene and grooming needs	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A9: Using currently prescribed equipment or treatment	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
E1: Taking medications	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
E2: Avoiding health and safety hazards	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

SIS activity:	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours=	Enter one time for each SIS activity
E4: Ambulating and moving about	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0 or more	0	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
				Daily critical support time score=	Sum of all times entered.

[08-15-091, recodified as § 388-828-9660, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10300, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9670 How does the residential algorithm calculate your mid-frequency critical support time? The residential algorithm uses the following chart to calculate your mid-frequency critical support time score:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)					
SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
A1: Using the toilet	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
A3: Preparing food	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A4: Eating food*	1 or more	0	0 or more	0	
		1	0 or more	0	

SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
A5: Housekeeping and cleaning	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
A6: Dressing*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
A7: Bathing and taking care of personal hygiene and grooming needs*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
A9: Using currently prescribed equipment or treatment*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
B2: Participating in recreation/leisure activities in community settings	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
B7: Interacting with community members	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
E1: Taking medications*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
E2: Avoiding health and safety hazards*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	
E4: Ambulating and moving about*	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0 or more	0	
		4	0 or more	0	

SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
G3: Protecting self from exploitation	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
				Mid-frequency critical support time score =	Sum of all times entered
	*Daily support activities that have less than daily support needs are added into the mid-frequency critical support time score.				

[08-15-091, recodified as § 388-828-9670, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10320, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9680 How does the residential algorithm determine your weekly critical support time? The residential algorithm uses the following chart to calculate your weekly critical support time score:

Qualifying Scores from Supports Intensity Scale (per WAC 388-828-4200 through 388-828-4320)					
SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours =	Enter one time for each SIS activity
A2: Taking care of clothes (including laundering)	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
B3: Using public services in the community	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours=	Enter one time for each SIS activity
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
B6: Shopping and purchasing goods and services	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
F2: Participating in recreation and/or leisure activities with others	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
F8: Engaging in volunteer work	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	

SIS Activity	If your type of support is:	And your frequency of support score is:	And your daily support time score is:	Then your critical task hours=	Enter one time for each SIS activity
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
G2: Managing money and personal finances	1 or more	0	0 or more	0	
		1	0 or more	0	
		2	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		3	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
		4	0	0	
			1	.25	
			2	1	
			3	3	
			4	5	
				Weekly critical support time score =	Sum of all times entered

[08-15-091, recodified as § 388-828-9680, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10340, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9690 How does the residential algorithm calculate your total critical support time (CST)? The residential algorithm uses the following formula to calculate your total critical support time (CST):

$$\frac{DailyCST}{1} + \frac{MidFreqCST}{3} + \frac{WeeklyCST}{7} = Total\ CST\ (hours\ per\ day)$$

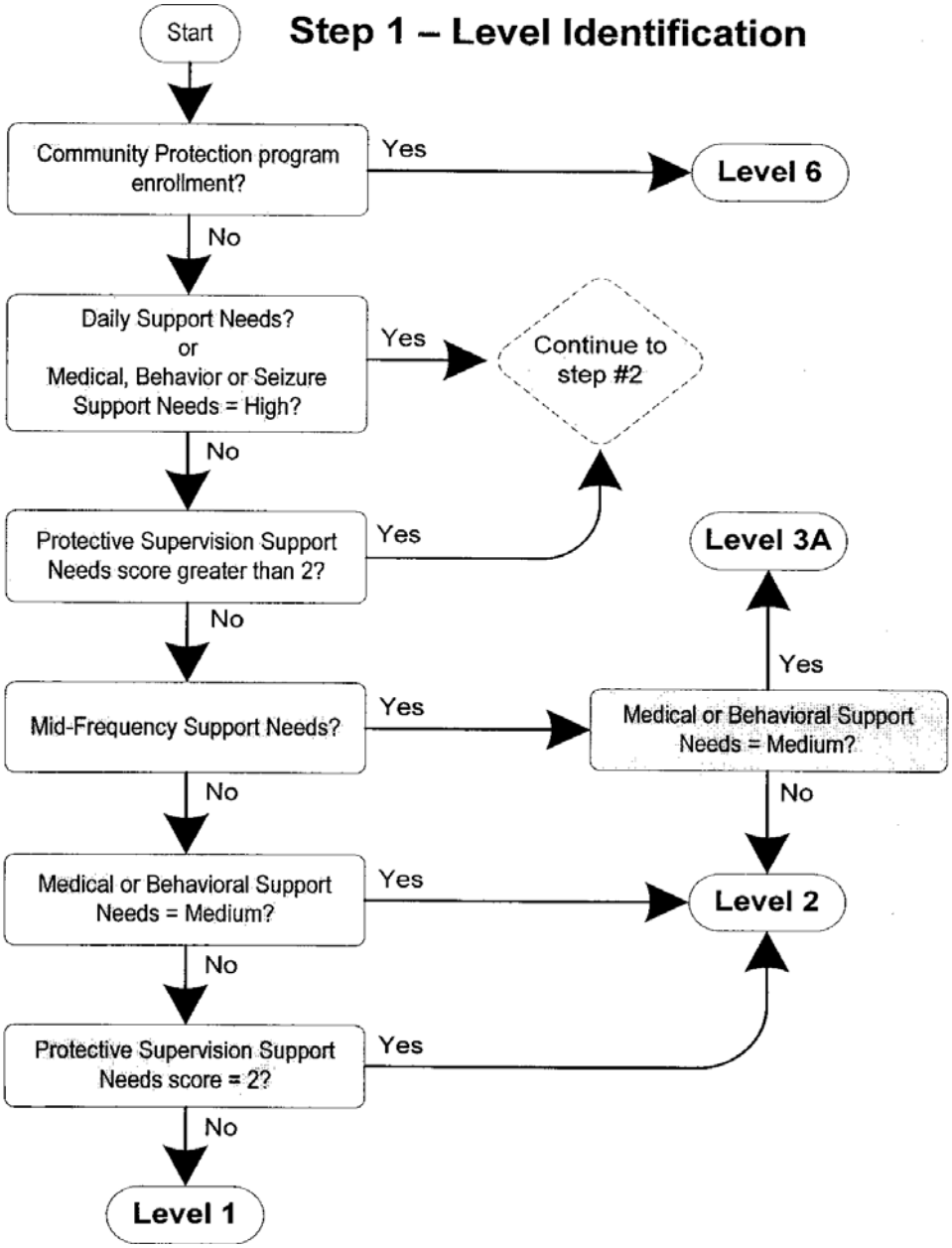
[08-15-091, recodified as § 388-828-9690, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10360, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9700 How does the residential algorithm use your assessed support needs scores to determine your residential service level of support? (1) The residential algorithm uses your assessed support needs scores (as defined in WAC 388-828-10100 [WAC 388-828-9550] through 388-828-10300 [388-828-9660]) to answer questions in a decision tree.

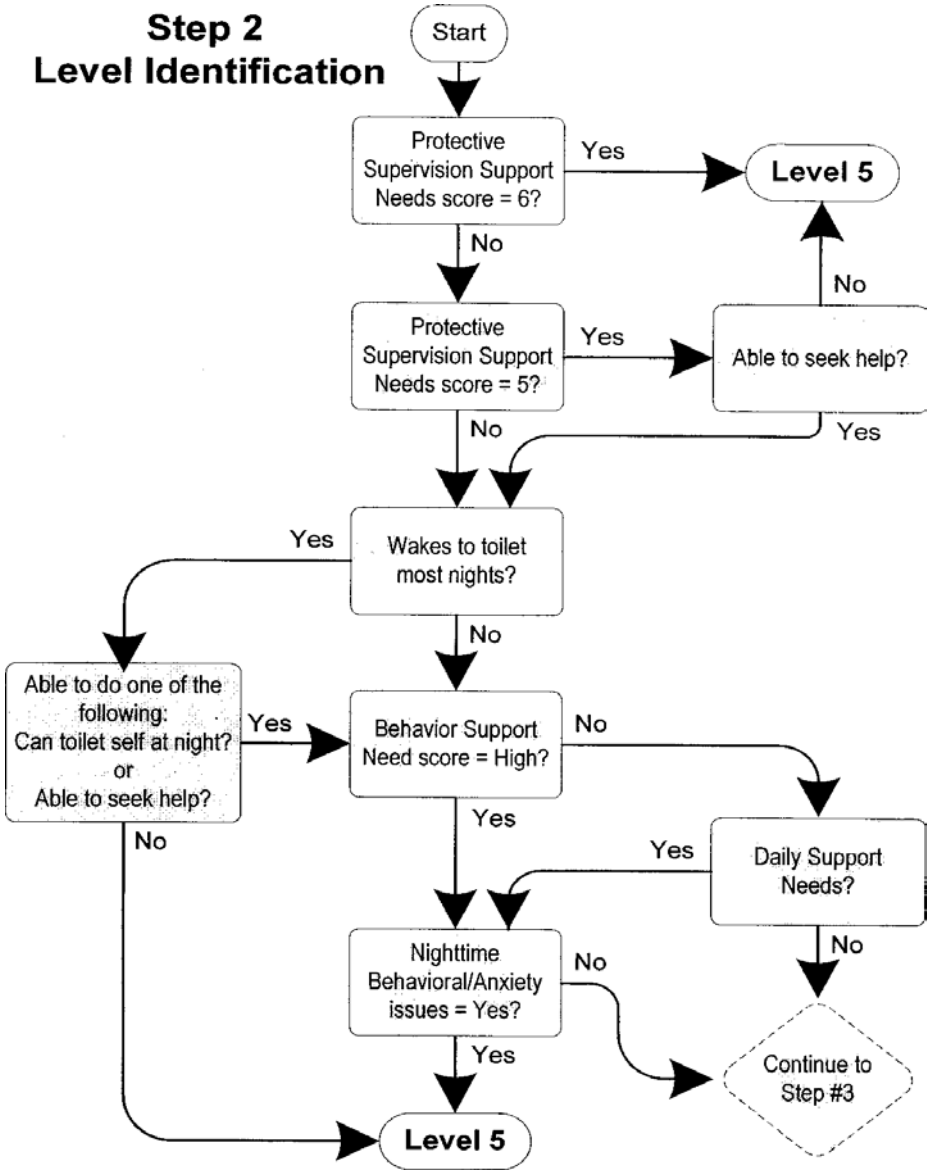
(2) The decision tree path determines your residential service level of support (WAC 388-828-10080 [WAC 388-828-9540]).

(3) The decision tree is separated into the following three steps:

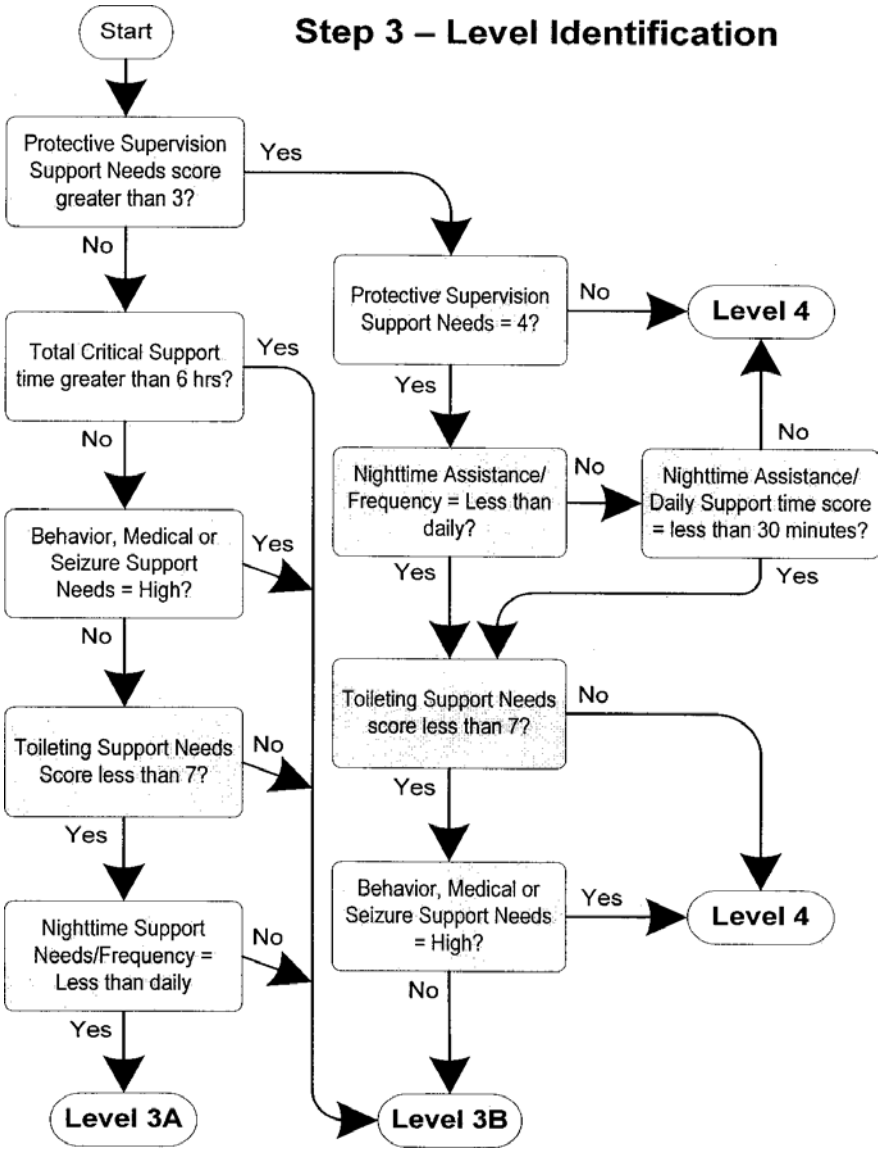
(a) Step 1 determines whether your residential support needs scores meet the criteria for less than daily support or the criteria for community protection.



(b) Step 2 determines whether your residential support needs scores meet the criteria for continuous day and night support.



(c) Step 3 determines whether your residential support needs scores meet the criteria for intermittent support.



[08-15-091, recodified as § 388-828-9700, filed 7/17/08, effective 7/17/08. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 08-12-037, § 388-828-10380, filed 5/30/08, effective 7/1/08.]

Chapter 388-829A WAC
ALTERNATIVE LIVING

WAC

PURPOSE

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.]

DEFINITIONS

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.]

ALTERNATIVE LIVING SERVICES

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.]

PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

WAC 388-829A-110 What minimum skills and abilities must alternative living procedures 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.]

PROVIDER TRAINING

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.]

PROVIDER RECORDS

WAC 388-829A-170 What information must alternative living providers keep in their records? Alternative living 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.]

ABUSE AND NEGLECT

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.]

EMERGENCY PLANNING

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.]

INDIVIDUAL SUPPORT PLAN

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.]

TRANSPORTATION

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.]

OVERSIGHT AND MONITORING OF ALTERNATIVE LIVING SERVICES

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.]

TERMINATION AND DENIAL OF AN ALTERNATIVE LIVING CONTRACT

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.]

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.]

APPEAL RIGHTS

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

PURPOSE

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.]

DEFINITIONS

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.]

COMPANION HOME SERVICES

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 43.20A710;

(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.]

PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

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.]

PROVIDER TRAINING

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.]

ABUSE AND NEGLECT REPORTING

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.]

HEALTH CARE AND MEDICATIONS

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.

Medication Assistance Task	May a companion home provider complete this task if the client meets both criteria in (a) and (b) of this section?
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

Medication Assistance Task	May a companion home provider complete this task if the client meets both criteria in (a) and (b) of this section?
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 prefilled 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 register 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.]

INDIVIDUAL SUPPORT PLAN

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.]

RESPITE

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.]

TRANSPORTATION

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.]

MANAGEMENT OF CLIENT FUNDS

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.]

SAFETY

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.]

PROVIDER RECORDS

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.]

EMERGENCY PLANNING

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.]

EVALUATION OF COMPANION HOMES

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.]

TERMINATION AND DENIAL OF A COMPANION HOME CONTRACT

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.]

APPEAL RIGHTS

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 388-831 WAC
COMMUNITY PROTECTION PROGRAM

WAC

WAC 388-831-0010 Definitions. The definitions in this section apply throughout the chapter unless the context clearly requires otherwise.

"Certified community protection program residential services" means access to twenty-four hour supervision, instruction, and support services as identified in the person's individual support plan.

"Community protection program" See WAC 388-831-0020.

"Constitutes a risk to others" means a determination of a person's risk and/or dangerousness based upon a thorough assessment by a qualified professional. Actuarial risk assessment instruments should be used to supplement clinical judgment whenever appropriate.

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

"Developmental disability" means that condition defined in WAC 388-823-0040 and RCW 71A.10.020(3).

"Disclosure" means providing copies of professional assessments, incident reports, legal documents, and other information pertaining to community protection issues to ensure the provider has all relevant information. Polygraph and plethysmograph reports are excluded from disclosure.

"Division" means the division of developmental disabilities (DDD).

"Managed successfully" means that a person supported by a community protection program does not engage in the behavior identified in WAC 388-831-0030 and RCW 71A.12.210.

"Opportunistic behavior" means an act committed on impulse, which is not premeditated. In determining whether an act is opportunistic, the original motive or intent of the offense or crime will be considered.

"Predatory" means acts directed toward strangers, individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or casual acquaintances with whom no substantial personal relationship exists. Predatory behavior may be characterized by planning and/or rehearsing the act, stalking, and/or grooming the victim.

"Program participant" means a person who has agreed to and is receiving services and supports in the community protection program.

"Qualified professional" means a licensed psychologist, psychiatrist, or a certified or affiliate sex offender treatment provider with at least three years prior experience working with individuals with developmental disabilities, and:

• If the person being assessed has demonstrated sexually aggressive or sexually violent behavior, that person must be assessed by a certified sex offender treatment provider, or affiliate sex offender treatment provider working under the supervision of a certified sex offender treatment provider; or

• If the person being assessed has demonstrated violent, dangerous, or aggressive behavior, that person must be assessed by a licensed psychologist or psychiatrist who has received specialized training in the treatment of or has at least three years prior experience treating violent or aggressive behavior.

"Restrictive procedures" or "Restrictions" means procedures that restrict a client's freedom of movement, restrict access to client property, prevent a client from doing something the client wants to do, require a client to do something the client does not want to do, or remove something the client owns or has earned.

"Risk assessment" means the written opinion of a qualified professional stating, at a minimum:

• Whether a person meets the criteria in WAC 388-831-0030 and RCW 71A.12.210; and

• What restrictions are necessary to keep people safe.

"Service provider" means a person or agency contracted with the department or a sub-contractor who delivers services and supports to a community protection program participant.

"Specialized environment" means a place where the program participant has agreed to supervision in a safe, structured manner specifying rules, requirements, restrictions, and expectations for personal responsibility in order to maximize community safety.

"Treatment team" means the program participant and the group of people responsible for the development, implementation, and monitoring of the person's individual supports and services. This group may include, but is not limited to, the case resource manager, therapist, residential provider, employment/day program provider, and the person's legal

representative and/or family, provided the person agrees to the family member's involvement.

"Violent offense" means any felony defined as a violent offense in RCW 9.94A.030.

"Waiver" means the community-based program funded under section 1915(c) of Title XIX of the federal social security act and chapter 388-845 WAC.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0010, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0020 What is the community protection program? (1) The community protection program is an array of services specifically designed to support persons who meet the definition of an "individual with community protection issues," as defined in WAC 388-831-0030.

(2) Community protection services and supports are designed to assist program participants to live safely and successfully in the community while minimizing the risk to public safety.

(3) Participation in the program is voluntary.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0020, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0030 Who are individuals with community protection issues? You are considered an individual with community protection issues if:

(1) You have been determined to have a developmental disability as defined in WAC 388-823-0040 and RCW 71A.10.020(3); and

(2) You have been identified by DDD as a person who meets one or more of the following:

(a) You have been charged with or convicted of a crime of sexual violence as defined in chapter 9A.44 or 71.09 RCW;

(b) You have been charged with or convicted of a crime involving sexual 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 charged with or convicted of one or more violent crimes as defined in RCW 9.94A.030(45);

(d) You have not been charged with or convicted of a crime identified in (2)(a), (b), or (c) above, 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; and

(3) You constitute a current risk to others as determined by a qualified professional.

(4) Charges or crimes that result in acquittal are excluded.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0030, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0040 Who is covered by these rules? These rules cover persons who are age eighteen or older and meet the criteria defined in WAC 388-831-0030.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0040, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0050 What steps are necessary for me to receive services through the community protection program? In order to receive services through the community protection program, you must:

(1) Receive an assessment of risk and/or dangerousness by a qualified professional, as specified in WAC 388-831-0060;

(a) You and your representative have the right to choose the qualified professional who is contracted with the state;

(b) The division will provide you with a list of these qualified professionals; and

(2) Be informed of the information contained in WAC 388-831-0070.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0050, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0060 What is contained in the risk assessment? (1) The risk assessment must be consistent with the guidelines for risk assessments and psychological or psychosexual evaluations developed by the division.

(2) The risk assessment must contain:

(a) A determination by a qualified professional whether your behaviors can be managed successfully in the community with reasonably available safeguards;

(b) A determination that lesser restrictive residential placement alternatives have been considered and would not be reasonable for your situation;

(c) Recommendations for treatment; and

(d) A list of necessary restrictions and the reason for them.

(3) The division may request an additional evaluation by a qualified professional who is contracted with the state.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0060, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0065 What if I refuse to participate in the risk assessment? (1) If you refuse to participate in the risk assessment, the division cannot determine what your health and safety needs are, or whether you can be supported successfully in the community with reasonable safeguards. You will not be eligible for any division services except for case management and medicaid personal care (if eligible under chapter 388-106 WAC).

(2) Your name will be placed on the specialized client database. This database identifies individuals who may present a danger to their communities.

(3) If DDD determines it can provide only case management and personal care, you and your legal representative will receive a notice of the determination that explains the decision and your right to appeal that decision.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0065, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0070 What type of information will I receive from the division when I am considered for placement in the community protection program? When you are considered for placement in the community protection program, the division will provide you and your legal representative the following information in writing:

(1) Limitations regarding the services that will be available due to your community protection issues;

(2) Disclosure requirements as a condition of receiving services other than case management;

(3) The requirement to engage in therapeutic treatment if it is a condition of receiving certain services;

(4) Anticipated restrictions that may be provided, such as intensive supervision and/or limited access to television viewing, reading material and videos;

(5) The right to decline services;

(6) The anticipated consequences of declining services, such as the loss of existing services and/or removal from waiver services;

(7) The right to an administrative hearing as specified in WAC 388-825-120 through 388-825-165, including an emergency adjudicative proceeding as specified in RCW 34.05.-479;

(8) The requirement to sign a preplacement agreement as a condition of receiving community protection program residential services;

(9) The right to retain current services as specified in WAC 388-825-145 or 388-825-150;

(10) The right to refuse to participate in the program; and

(11) Information about how to contact a disability rights organization.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0070, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0080 Will I be notified of the division's determination regarding placement in the community protection program? (1) If the division determines that you are appropriate for placement in the community protection program, you and your legal representative will receive in writing a determination by the division that you meet the criteria for placement within the community protection program and your right to appeal this decision.

(2) This notification does not guarantee placement within the community protection program.

(3) If the division determines that you are not appropriate for placement in the community protection program, you and your legal representative will receive a notice in writing of the determination by the division that you do not meet the criteria for placement within the community protection program.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0080, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0090 Will I be notified if the division determines that I cannot be managed successfully in the community protection program? If the division determines that your health and safety needs cannot be met and you cannot be managed successfully in the community protection program with reasonably available safeguards, you and your legal representative will receive this determination in writing.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0090, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0100 How do I apply for the community protection program? (1) You may apply for the community protection program by calling the regional DDD office or a local DDD office. The toll free regional numbers are:

Region 1	Spokane	1-800-462-0624
Region 2	Yakima	1-800-822-7840
Region 3	Everett	1-800-788-2053
	Bellingham	1-800-239-8285
	Mount Vernon	1-800-491-5266
Region 4	Seattle	1-800-314-3296
Region 5	Tacoma	1-800-248-0949
	Bremerton	1-800-735-6740
Region 6	Port Angeles	1-877-601-2760
	Tumwater	1-800-339-8227
	Vancouver	1-888-877-3490

(2) DDD will make arrangements with you to complete the application for the eligibility determination by mail or over the phone.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0100, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0110 What information about me will be shared with others if I am offered services in the community protection program? (1) If you are offered services in the community protection program, the division will give information about you and your community protection issues to:

(a) Prospective community protection service providers; and

(b) Your current service providers.

(2) The division will not authorize any services without disclosure of your community protection issues.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0110, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0120 What will my services be like in the community protection program? Your community protection services will be:

(1) Consistent with your individual support and supervision needs as specified in your individual support plan;

(2) Consistent with your individual treatment plan, which includes your most recent treatment goals and current restrictions; and

(3) Provided in the least restrictive manner and environment that minimizes the likelihood of offending behavior.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0120, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0130 What services may I receive in the community protection program? (1) The division will only authorize services to program participants who follow the treatment recommendations made by the qualified professionals who assess and/or provide your treatment and are listed in WAC 388-845-0220.

(2) Your residential services must be provided by a certified community protection intensive supported living services provider. Community protection intensive supported living services provide:

(a) An opportunity for you to live successfully in the community;

(b) A specialized environment in which you are supported to make positive choices to reduce the behaviors that require intensive intervention and supervision.

(3) Your employment services as defined in WAC 388-845-1200, 388-845-1400, and 388-845-2100 must be provided by a qualified community protection employment program service provider.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0130, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0150 Who can provide my therapy in the community protection program? You and your representative have the right to choose the qualified professional to provide your therapy, subject to the following conditions:

(1) Your therapy must be provided by a qualified professional who:

(a) Has at least three years experience treating individuals with developmental disabilities and community protection issues;

(b) Is in good standing with the department of health, health professions quality assurance division;

(c) Is within a reasonable distance of your residence; and

(d) Is contracted with the department.

(2) Only a certified sex offender treatment provider (SOTP) or an affiliate sex offender treatment provider working under the supervision of a certified SOTP may provide sexual deviancy treatment.

(3) Any restrictive procedures used during your therapy or as part of your treatment must follow requirements for restrictive procedures developed by the department.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0150, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0160 What services may I receive if I refuse placement in the community protection program? If you are offered and refuse community protection program residential services, you may only receive case management services and medicaid personal care (if eligible under chapter 388-106 WAC).

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0160, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0200 How often will my progress be reviewed? (1) The treatment team will review your progress at least every ninety days.

(2) If a treatment team member has reason to believe that your circumstances have changed significantly, the team member may request that a risk reassessment be conducted at any time.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0200, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0210 What is included in the review of my progress? (1) The review of your progress will include:

(a) Evaluating the use of less restrictive measures;

(b) Making changes in your program as necessary;

(c) Reviewing all restrictions and recommending reductions, if appropriate.

(2) The therapist must write a report annually evaluating your risk of offense and/or risk of behaviors that are dangerous to you or others.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0210, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0220 When may I be considered for placement in a less restrictive residential setting? (1) If you demonstrate success in complying with reduced restrictions and remain free of any offense that may indicate a relapse for at least twelve months, you may be considered for placement in a less restrictive residential setting.

(2) If you request placement in a less restrictive residential setting and that request is denied, you and your legal representative will receive a notice of the determination by DDD, explaining the reason for the denial and your right to appeal this decision.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0220, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0230 What is the process to move me to a less restrictive residential setting? (1) The process to move you to a less restrictive residential setting will include:

(a) Written verification of your treatment progress and an assessment of low risk of reoffense and/or dangerousness by your therapist;

(b) A recommendation by your therapist that you are ready for reductions in supervision and restrictions;

(c) Development of a gradual phase out plan by the treatment team, projected over a reasonable period of time, which includes specific criteria for evaluating reductions in restrictions, especially supervision;

(d) Compliance with reduced restrictions;

(e) The absence of any incidents that may indicate relapse for a period of twelve months;

(f) An assessment by a qualified professional consistent with the division guidelines for risk assessment and psychosexual evaluations containing:

(i) An evaluation of your risk of reoffense and/or dangerousness; and

(ii) An opinion as to whether or not you can be managed successfully in a less restrictive community residential setting; and

(g) A recommendation as to suitable placement by the treatment team.

(2) When the treatment team agrees that you are ready to move to a less restrictive community residential placement, you will receive a written plan that details what supports and services, including the level of supervision, you will receive in the less restrictive community residential placement.

(3) If you meet the eligibility requirements described in WAC 388-845-0030, you are eligible for waiver services and will be placed on a waiver that meets your needs.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0230, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0240 Can I be terminated from the community protection program? You may be terminated from the community protection program by the division if:

(1) You physically assault program participants, staff or others;

(2) You repeatedly elope from the program or evade supervision;

(3) You engage in illegal behavior of any kind; or

(4) You refuse to comply with program and/or treatment guidelines to the extent that your therapist determines you are not amenable to treatment; or

(5) The division determines that your health and safety needs cannot be met in the program.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0240, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0250 Can I leave the community protection program at any time? Your participation in the community protection program is voluntary. However, if you leave the community protection program and DDD determines that you require the community protection program to meet your health and safety needs and those of the community, you will not be eligible for other DDD residential services or employment/day program services.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0250, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0260 What enforcement actions may the division take against a provider of residential services and support? The rules regarding the enforcement actions that the division may take against a provider of residential services and support may be found in WAC 388-101-4150 through 388-101-4190.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0260, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0300 What appeal rights do I have if I receive services through the division's community protection waiver? (1) You have the right to appeal decisions made by the division in accordance with WAC 388-825-120 through 388-825-165.

(2) In addition to the right to appeal department actions described in WAC 388-825-120(3), if you receive services through the division's community protection waiver you have the right to appeal the following decisions by the division:

(a) Termination of community protection waiver eligibility;

(b) Your assignment to the community protection waiver; and

(c) Denial of a request for a less restrictive community residential placement.

(3) You may appeal final administrative decisions pursuant to the provisions of RCW 34.05.510 through 34.05.598.

(4) You do not have the right to an administrative hearing on the division's decision denying you placement on the community protection waiver.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0300, filed 9/30/08, effective 10/31/08.]

WAC 388-831-0400 Am I entitled to placement on the community protection waiver? Nothing in these rules creates an entitlement to placement on the community protection waiver.

[Statutory Authority: RCW 71A.12.030 and 2006 c 303. 08-20-118, § 388-831-0400, filed 9/30/08, effective 10/31/08.]

Chapter 388-832 WAC
INDIVIDUAL AND FAMILY SERVICES PROGRAM

WAC

WAC 388-832-0001 What definitions apply to this chapter? The following definitions apply to this chapter:

"Agency provider" means a licensed and/or ADSA certified business that is contracted with ADSA or a county to provide DDD services (e.g., personal care, respite care, residential services, therapy, nursing, employment, etc.).

"Allocation" means an amount of funding available to the client and family for a maximum of twelve months, based upon assessed need.

"Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment of a service.

"Back-up caregiver" is a person who has been identified as an informal caregiver and is available to provide assistance as an informal caregiver when other caregivers are unavailable.

"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.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration (ADSA), department of social and health services (DSHS).

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

"Emergency" means the client's health or safety is in jeopardy.

"Family" means individuals, of any age, living together in the same household and related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Family home" means the residence where you and your relatives live.

"Formal caregiver" is a person/agency who receives payment from DDD to provide a service.

"Individual provider" means an individual who is contracted with DDD to provide medicaid or waiver personal care, respite care, or attendant care services.

"Individual support plan" or **"ISP"** is a document that authorizes the DDD paid services to meet a client's needs identified in the DDD assessment.

"Informal caregiver" is a person who provides supports without payment from DDD for a service.

"Legal guardian" means a person/agency, appointed by a court, which 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 guardian for their child until the child reaches the age of eighteen.

"Parent family support contract" means a contract between DDD and the parent to reimburse the parent for the purchase of goods and services paid for by the parent.

"Pass through contract" means a contract between DDD and a third party to reimburse the third party for the purchase of goods and services paid for by the third party.

"Primary caregiver" is the formal or informal caregiver who provides the most support.

"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.

"Significant change" means changes in your medical condition, caregiver status, behavior, living situation or employment status.

"State funded services" means services that are funded entirely with state dollars.

"State supplementary payment" or **"SSP"** means a state paid cash assistance program for certain DDD clients eligible for supplemental security income per chapter 388-827 WAC.

"You" means the client.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0001, filed 8/5/08, effective 9/5/08.]

DESCRIPTION

WAC 388-832-0005 What is the individual and family services program? The "individual and family services program" (IFS program) is a state-only funded program that:

(1) Provides an array of services to families to help maintain and stabilize the family unit; and

(2) Replaces WAC 388-825-200 through 388-825-242 (the family support opportunity program), WAC 388-825-252 through 388-825-256 (the traditional family support program), WAC 388-825-500 through 388-825-595, (the flexible family support pilot program), and WAC 388-825-244 through 388-825-250 (other family support rules).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0005, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0007 What is the purpose of the individual and family services (IFS) program? The purpose of the IFS program is to have one DDD family support program that will:

(1) Form a partnership between the state and families to help support families who have a client of DDD living in the family home; and

(2) Provide families with a choice of services and allow families more control over the resources allocated to them.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0007, filed 8/5/08, effective 9/5/08.]

ELIGIBILITY

WAC 388-832-0015 Am I eligible to participate in the IFS program? (1) You are eligible to be considered for the IFS program if you meet the following criteria:

(a) You are currently an eligible client of DDD;

(b) You live in your family home;

(c) You are not enrolled in a DDD home and community based services waiver defined in chapter 388-845 WAC;

(d) You are currently enrolled in traditional family support, family support opportunity or the family support pilot or funding has been approved for you to receive IFS program services;

(e) You are age three or older as of July 1, 2007;

(f) You have been assessed as having a need for IFS program services as listed in WAC 388-832-0140; and

(g) You are not receiving a DDD residential service.

(2) If you are a parent, you are eligible to receive IFS program services in order to promote the integrity of the family unit, provided:

(a) You meet the criteria in subsections (1)(a) through (f) above; and

(b) Your child who lives in your home is at risk of being placed up for adoption or into foster care.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0015, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0020 Will I be authorized to receive IFS services if I meet the eligibility criteria in WAC 388-832-0015? Meeting eligibility criteria for the IFS program does not ensure access to or receipt of the IFS program services.

(1) Receipt of IFS services is limited by availability of funding and your assessed need.

(2) WAC 388-832-0085 through 388-832-0090 describes how DDD will determine who will be approved to receive funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0020, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0022 What determines the allocation of funds available to me to purchase IFS services? The allocation of funds is based upon the IFS assessment described in chapter 388-828 WAC. The DDD assessment will determine your service level based on your assessed need.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0022, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0023 If I qualify for another DDD service, will my IFS program be reduced or terminated? Since your IFS amount is based on the assessed need, if your needs change, the dollar amount will be impacted. However, if you are qualified for another DDD service, you can still receive IFS as long as you continue to have an assessed need and have met the eligibility criteria for the IFS program.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0023, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0024 If I participate in the IFS program, will I be eligible for services through the DDD home and community based services (HCBS) waiver? (1) If you participate in the IFS program you may not participate in the DDD HCBS waiver at the same time.

(2) You may request enrollment in a DDD HCBS waiver at any time per WAC 388-845-0050.

(3) Participation in the IFS program will not affect your potential waiver eligibility.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0024, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0025 Am I eligible for the IFS program if I currently receive other DDD paid services? If you receive other nonwaiver DDD funded services, you may be eligible for the IFS program.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0025, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0045 What if there are two or more family members who are eligible for the IFS program? If there are two or more family members who are eligible for the IFS program, each family member will be assessed to determine their IFS program allocation based on their individual need.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0045, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0050 How do I request IFS program services? You may contact your DDD case/resource manager at any time to request IFS program services. You will receive written notice of DDD's approval or denial along with your administrative hearing rights.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0050, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0055 How long do I remain eligible for the IFS program? To remain eligible for the IFS program you must be reassessed at least every twelve months or sooner if there is a significant change in your needs per WAC 388-828-1500 and you must meet all eligibility criteria described in WAC 388-832-0015.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0055, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0060 Can DDD terminate my eligibility for the IFS program? You may be terminated from the IFS program for any of the following reasons:

(1) You no longer meet DDD eligibility per WAC 388-823-0010 through 388-823-0170;

(2) You no longer meet the eligibility criteria for the IFS program per WAC 388-832-0015;

(3) You have not used an IFS program service during the last twelve calendar months;

(4) You cannot be located or do not make yourself available for the annual DDD assessment;

(5) You refuse to participate with DDD in service planning; and/or

(6) You begin to receive a DDD residential service.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0060, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0065 If I go into a temporary out of home placement, will I be eligible for IFS upon my return home? You can apply for the IFS program once you return home from placement by contacting your DDD case manager, if your out of home placement does not exceed twelve months. Your case manager will schedule an assessment with you and, if you meet all the eligibility criteria described in WAC 388-832-0015, have an assessed need, and funding is available, you will receive an IFS program allocation.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0065, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0067 If I am a parent with a developmental disability and a client of DDD, are my children eligible for IFS program services? If you are a parent with a developmental disability and a client of DDD, your children may be eligible for IFS program services if funding is available and your children:

(1) Are ages birth through twenty-one years of age;

(2) Are at risk of out of home placement; and

(3) Live with you.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0067, filed 8/5/08, effective 9/5/08.]

INDIVIDUAL AND FAMILY SERVICES PROGRAM WAIT LIST

WAC 388-832-0070 What is the IFS program wait list? The IFS wait list is a list of clients who live with their family and the family has requested family support services. At the time of the family's request for IFS program services, funding was not available; therefore these clients were placed on the IFS program wait list effective on the date of their request.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0070, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0072 Who is eligible to be on the IFS program wait list? To be on the IFS wait list you must live in your family home and remain eligible for DDD services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0072, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0075 Do I have to have a DDD assessment before I can be added to the IFS wait list? You do not have to have a DDD assessment prior to your name being added to the IFS wait list.

(1) Your name and request date will be added to the wait list.

(2) A notice will be sent to you to let you know your name has been added to the IFS wait list.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0075, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0080 How or when am I taken off the IFS wait list? You are taken off the wait list if:

(1) You no longer live in your family home;

(2) You are no longer eligible for DDD services;

(3) You request your name to be removed from the IFS wait list;

(4) You do not respond to IFS notification to schedule the DDD assessment;

(5) You are offered IFS services and accept or refuse services;

(6) You are on the HCBS waiver; or

(7) Your DDD assessment determines you are not eligible for the IFS program.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0080, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0082 If the DDD assessment determines I am not eligible for the IFS program, may I remain on the IFS wait list? If the DDD assessment determines you

are not eligible for the IFS program, you may remain on the wait list; however, your request date will change to the date of your current assessment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0082, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0085 When there is state funding available to enroll new clients in the IFS program, how will DDD select from the clients on the IFS program wait list? When there is state funding available for new IFS participants, DDD may enroll participants based on the following considerations:

(1) Clients who have requested residential habilitation center (RHC) respite, emergency services, or residential placement, prior to June 30, 2007.

(2) Clients with the highest scores in caregiver and behavior status on the mini assessment.

(3) Clients who have been on the IFS program wait list the longest.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0085, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0087 What happens next if I am selected from the IFS program wait list? If you are selected from the IFS program wait list:

(1) Your DDD case/resource manager will contact you, and determine if you meet the eligibility criteria for IFS program per WAC 388-832-0015 (1) though (6);

(2) If you meet the criteria per (1) above, your case/resource manager will schedule an appointment to complete your DDD assessment or reassessment.

(3) If you have not been receiving any DDD paid services, your DDD eligibility will need to be reviewed per WAC 388-823-1010(3)

(4) Your DDD eligibility must be completed prior to completing the DDD assessment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0087, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0090 If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will I qualify for the IFS program? If you currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, you qualify for the IFS program if you meet the eligibility criteria in WAC 388-832-0015.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0090, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0091 If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will that funding continue until my next assessment? If you currently receive funding from the traditional family support (TFS) program, the family support opportunity (FSO) program or the family support pilot (FSP) program, you will continue to receive funding under the TFS, FSO, or the FSP program until your next DDD assessment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0091, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0095 What happens if DDD finds me ineligible for the IFS program? If you do not meet the criteria for the IFS program, DDD will terminate your individual and family services eligibility and funding. You will receive written notice of this decision along with your administrative hearing rights.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0095, filed 8/5/08, effective 9/5/08.]

ASSESSMENT

WAC 388-832-0100 What assessment will DDD use to assess my need? The DDD assessment will be used to assess your need. The DDD assessment is an assessment tool designed to measure the support needs of persons with developmental disabilities, and is described in chapter 388-828 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0100, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0110 Will DDD ask about my family's income? DDD is required to request family income information for:

(1) Families of children who are seventeen years of age or younger; and

(2) All individuals who are receiving state-only funded services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0110, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0113 Will my IFS allocation be impacted by my income? The amount of services you receive will be solely based on your assessed needs. Your income will not affect your level of service.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0113, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0114 What is family income? Family income is defined as the total unadjusted, annual family (or household) income from all sources for the last calendar year as reported to the Internal Revenue Service (IRS).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0114, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0115 How is an individual's access to DDD paid services affected if family income information is not provided? An individual's access to DDD paid services is not affected when families decline to provide DDD with family income information.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0115, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0120 Will my IFS allocation be impacted if I am eligible for medicaid personal care services? If you meet financial and functional eligibility for medicaid personal care services, your IFS allocation will be adjusted according to WAC 388-828-9100 through 388-828-9140.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0120, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0123 Will my IFS allocation be impacted if I am eligible for private duty nursing or the medically intensive program? If you meet eligibility for private duty nursing described in WAC 388-106-1000, or the medically intensive program described in WAC 388-551-3000, your IFS allocation will be adjusted according to WAC 388-828-9100 through 388-828-9140.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0123, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0125 Will my IFS allocation be impacted if I am eligible for COPES? If you are eligible for COPES, your IFS allocation will not be adjusted.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0125, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0127 What if I have assessed needs that cannot be met by the IFS program? 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. In addition, DDD may:

(1) Provide information and referral for non-DDD community-based supports;

(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) Request short term emergency services as an exception to rule (ETR) per WAC 388-440-0001. Approval is required by the director of DDD or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0127, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0128 When is the individual support plan effective? (1) For an initial 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 the 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.12.040, and 2007 c 283. 08-16-121, § 388-832-0128, filed 8/5/08, effective 9/5/08.]

ALLOCATION

WAC 388-832-0130 What is the amount of the IFS program allocation my family is going to receive? The DDD assessment, described in chapter 388-828 WAC, will determine your level of need. The IFS program annual allocations are as follows:

(1) Level 1 - Up to $2,000;

(2) Level 2 - Up to $3,000;

(3) Level 3 - Up to $4,000; and

(4) Level 4 - Up to $6,000.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0130, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0132 May I request to exceed the level at which I was assessed? (1) The DDD assessment was designed to measure the support needs of persons with developmental disabilities; therefore your level may not exceed the level at which you were assessed.

(2) If a significant change occurs, you may contact your DDD case manager for a possible reassessment of your support needs.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0132, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0135 How can my family use its IFS program allocation? Your IFS program allocation is available to pay for any of the services listed in WAC 388-832-0140 if:

(1) The service need relates to and results from your developmental disability, and

(2) The need is identified in your DDD assessment and identified on your ISP.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0135, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0136 If I have a family support reimbursement contract, can DDD ask me to verify my purchases through reviewing receipts? (1) If you have a family support reimbursement contract, you will first need prior approval from your DDD case manager and then DDD will ask you to verify your purchases through reviewing receipts.

(2) You need to submit receipts to your case manager whenever you are asking for reimbursement.

(3) Your request for reimbursement must be received within ninety days of the date that the service was received and no later than thirty days after the end of your allocation year.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0136, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0137 May I use my allocation over a two year period for large costly expenditures? (1) You may not use your allocation over a two year period for a large costly expenditure.

(2) Your annual allocation must be used during the twelve month period your assessed needs were determined.

(3) If you do not use all of your allocation, your remaining dollars do not carry over to next year's allocation.

(4) If at least some of your IFS program services are not used in the twelve month period, you will be terminated from the IFS program.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0137, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0139 If I have a significant change assessment, what happens to my allocation? If you have a significant change assessment, one of the following changes may occur under WAC 388-828-9000 through 388-828-9140:

(1) If the algorithm does not change your IFS program level, your funding will not change.

(2) If the algorithm changes your level to a higher IFS program level, the difference is added to your fiscal years allocation.

(3) If the algorithm changes your level to a lower IFS program level, your allocation will not be changed until your next annual assessment. At that time your allocation will be calculated with your current information.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0139, filed 8/5/08, effective 9/5/08.]

SERVICES

WAC 388-832-0140 What services are available through the IFS program? The services available in the IFS program are limited to the following:

(1) Respite care (WAC 388-832-0143 through 388-832-0160);

(2) Therapies (WAC 388-832-0170 through 388-832-0180):

(a) Physical therapy (PT);

(b) Occupational therapy (OT); and

(c) Speech, language and communication therapy.

(3) Architectural and vehicular modifications (WAC 388-832-0185 through 388-832-0189);

(4) Specialized medical equipment and supplies (WAC 388-832-0200 through 388-832-0210);

(5) Specialized nutrition and clothing (WAC 388-832-0215 through 388-832-0225);

(6) Excess medical costs not covered by another source (WAC 388-832-0165 through 388-832-0168);

(7) Copays for medical and therapeutic services (WAC 388-832-0235 through 388-832-0245);

(8) Transportation (WAC 388-832-0250 through 388-832-0260);

(9) Training and counseling (WAC 388-832-0265 through 388-832-0275);

(10) Behavior management (WAC 388-832-0280 through 388-832-0290);

(11) Parent/sibling education (WAC 388-832-0300 through 388-832-0310);

(12) Recreational opportunities (WAC 388-832-0315 through 388-832-0325); and

(13) Community service grants (WAC 388-832-0370 through 388-832-0375).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0140, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0143 What is respite care? Respite care is short term intermittent relief for persons normally providing care for individuals receiving IFS program services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0143, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0145 Who is eligible to receive respite care? You are eligible to receive respite care if you are approved for IFS program services and:

(1) You live in your family home and no one living with you is paid to be your caregiver.

(2) You live with a paid caregiver who is your natural, step, or adoptive parent.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0145, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0150 Where can respite care be provided? (1) Respite care can be provided in the following location(s):

(a) Individual's family home; or

(b) Relative's home.

(2) Respite care can be also be provided in the following location(s) but require a DDD agency respite contract:

(a) Licensed children's foster home;

(b) Licensed, contracted and DDD certified group home;

(c) Licensed boarding home contracted as an adult residential center;

(d) Licensed and contracted adult family home;

(e) Children's licensed group home, licensed staffed residential home, or licensed childcare center; or

(f) Adult day health.

(3) Additionally, your respite care provider may take you into the community while providing respite care.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0150, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0155 Who are qualified providers of respite care? Providers of respite care can be any of the following 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 WAC 246-335-012(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 rehabilitation center under WAC 246-325-012;

(7) Licensed childcare center under chapter 388-295 WAC;

(8) Licensed child daycare center under chapter 388-295 WAC;

(9) Adult day/health care centers contracted with DDD; or

(10) Certified provider per chapter 388-101 WAC when respite is provided within the DDD contract for certified residential services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0155, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0160 Are there limits to the respite care I receive? The following limitations apply to the respite care you can receive:

(1) Respite cannot replace:

(a) Daycare, childcare or preschool 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.

(2) 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.

(d) The respite care provider cannot be your natural, step or adoptive parent living with you.

(3) Your caregiver will not be paid to provide DDD services for you or other persons at the same time you receive respite services.

(4) The need for respite must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(5) If your personal care provider is your parent, your parent provider may not be paid to provide respite services to any client in the same month that you receive respite services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0160, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0165 What are considered excess medical costs not covered by another source? Excess medical costs are medical expenses incurred by a client after medicaid or private insurance have been accessed or when the client does not have medical insurance. This may include the following:

(1) Skilled nursing services (ventilation, catheterization, and insulin shots);

(2) Psychiatric services;

(3) Medical and dental services related to the person's disability and an allowable medicaid covered expense;

(4) Prescriptions for medications; and/or

(5) Copays and deductible limited to your IFS allocation.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0165, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0166 How are excess medical costs paid? (1) Excess medical costs are reimbursed to a family member who has a family support contract with the division of developmental disabilities and receipts are received within thirty days from the date of service.

(2) Skilled nursing services are paid to the DSHS contracted nurse directly.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0166, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0168 Are there limits to excess medical costs? There are limits to excess medical costs.

(1) The payment must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability;

(2) Medical and dental premiums are excluded for family members other than the DDD eligible clients; and

(3) The need for excess medical costs must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(4) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0168, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0170 What therapies can I receive? The therapies you can receive are:

(1) Physical therapy;

(2) Occupational therapy; and/or

(3) Speech, hearing and language therapy.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0170, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0175 Who is a qualified therapist? Providers must be certified, registered or licensed therapists as required by law and contracted with DDD for the therapy they are providing.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0175, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0180 Are there limits to the therapy I can receive? The following limitations apply to therapy you may receive:

(1) Additional therapy may be authorized as a service only after you have accessed what is available to you under medicaid and any other private health insurance plan or school;

(2) DDD does not pay for treatment determined by DSHS to be experimental;

(3) DDD and the treating professional determine the need for and amount of service you can receive;

(a) DDD may require a second opinion from a DDD selected provider.

(b) DDD will require evidence that you have accessed your full benefits through medicaid, private insurance and the school before authorizing this service.

(4) The need for therapies must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocations.

(5) Prior approval by the regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0180, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0185 What are architectural and vehicular modifications? (1) Architectural and vehicular modifications are physical adaptations to the home and vehicle of the individual to:

(a) Ensure the health, welfare and safety of the client and or caregiver; or

(b) Enable a client who would otherwise require a more restrictive environment to function with greater independence in the home or in the community.

(2) Architectural modifications include the following:

(a) Installation of ramps and grab bars;

(b) Widening of doorways;

(c) Modification of bathroom facilities; or

(d) Installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

(3) Vehicular modifications include the following:

(a) Wheel chair lifts;

(b) Strap downs; or

(c) Other access modifications.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0185, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0190 Who is a qualified provider for architectural and vehicular modifications? The provider making these architectural and vehicular modifications must be a registered contractor per chapter 18.27 RCW and contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0190, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0195 What limits apply to architectural and vehicular modifications? The following service limitations apply to architectural and vehicular modifications are in addition to any limitations in other rules governing this service:

(1) Prior approval by the regional administrator or designee is required.

(2) Architectural and vehicular modifications to the home and vehicle are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as floor covering (e.g., carpeting, linoleum, tile, hard wood flooring, decking), roof repair, central air conditioning, fencing for the yard, etc.

(3) Architectural modifications cannot add to the square footage of the home.

(4) DDD will require evidence that you accessed your full benefits through medicaid, private insurance and the division of vocational rehabilitation (DVR) before authorizing this service.

(5) Architectural and vehicular modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDD.

(6) Architectural and vehicular modifications will be prorated by the number of other members in the household who use these modifications.

(7) The need for architectural and vehicular modifications must be identified in your ISP and, in combination with other IFS services, cannot exceed your annual IFS allocation.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0195, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0200 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.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0200, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0205 Who are qualified providers of specialized medical equipment and supplies? The provider of specialized medical equipment and supplies must be a medical equipment supplier contracted with DDD (or a parent who has a contract with DDD or the pass through contract).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0205, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0210 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 state funds shall be in addition to any medical equipment and supplies furnished under medicaid or private insurance.

(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 need for specialized medical equipment and supplies must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0210, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0215 What are specialized nutrition and specialized clothing? (1) Specialized nutrition is specialized formulas or specially prepared foods for which a written recommendation has been provided by a qualified and appropriate professional and when it constitutes fifty percent or more of the person's caloric intake (e.g., licensed physician or registered dietician).

(2) Specialized clothing is clothing adapted for a physical disability, excessive wear clothing, or specialized footwear for which a written recommendation has been provided by a qualified and appropriate professional (e.g., a podiatrist, physical therapist, or behavior specialist).

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0215, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0220 How do I pay for specialized nutrition and specialized clothing? Specialized nutrition and specialized clothing can be a reimbursable expense through the parent family support contract and the pass through contract.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0220, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0225 Are there limits for specialized nutrition and specialized clothing? (1) The need for specialized nutrition and specialized clothing must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(2) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0225, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0235 What are copays for medical and therapeutic services? Copays for medical and therapeutic services are for disability related services you may have received that were not covered by your private insurance or medicaid.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0235, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0240 How do I pay for medical and therapeutic copays? Medical and therapeutic copays can be a reimbursable expense through the parent family support contract and the pass through contract.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0240, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0245 Are there limits to medical and therapeutic copays? (1) Medical and therapeutic copays must be identified as a need in your ISP and, in combination with other IFS services, cannot exceed your IFS program allocation.

(2) The copays must be for your disability related medical or therapeutic needs.

(3) Prescribed or nonprescribed vitamins and supplements are excluded.

(4) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0245, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0250 What are transportation services? Transportation services are reimbursements to a provider when the transportation is required and specified in the individual support plan. This service is available for all IFS program services if the cost and responsibility for transportation is not already included in your provider's contract and payment.

(1) Transportation provides you access to IFS program services specified by your 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.12.040, and 2007 c 283. 08-16-121, § 388-832-0250, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0255 Who is a qualified provider for transportation services? (1) The provider of transportation services can be an individual or agency contracted with DDD.

(2) Transportation services can be a reimbursable expense through the parent family support contract.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0255, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0260 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 an IFS program 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) Transportation services require prior approval by the DDD regional administrator or designee.

(11) Per diem costs may be reimbursed with prior approval from DDD regional administrator or designee to access medical services if over one hundred fifty miles one way for client receiving medical services and one family member.

(12) Air ambulance costs due to an emergency may be reimbursed after insurance, deductibles, medicaid and other resources have been exhausted not to exceed your annual IFS allocation.

(13) The need for transportation services must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0260, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0265 What is training and counseling? Training and counseling is professional assistance provided to families to better meet the specific needs of the individual outlined in their ISP including:

(1) Health and medication monitoring;

(2) Positioning and transfer;

(3) Augmentative communication systems; and

(4) Family counseling.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0265, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0270 Who is a qualified provider for training and counseling? To provide training and counseling, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDD for the service specified in the individual support plan:

(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; or
(15) Certified dietician.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0270, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0275 Are there limitations to the training and counseling I can receive? (1) Expenses to the family for room and board or attendance, including registration fees for conferences are excluded as a service under family counseling and training.

(2) The need for training and counseling must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(3) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0275, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0280 What is behavior management? Behavior management is the development and implementation of programs designed to support the client using positive behavioral techniques. Behavior management programs help the client decrease aggressive, destructive, sexually inappropriate or other behaviors that compromises the client's ability to remain in the family home, and develop strategies for effectively relating to caregivers and other people in the client's life.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0280, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0285 Who is a qualified provider of behavior management? The provider of behavior management and consultation must be one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

(1) Marriage and family therapist;
(2) Mental health counselor;
(3) Psychologist;
(4) Sex offender treatment provider;
(5) Social worker;
(6) Registered nurse (RN) or licensed practical nurse (LPN);
(7) Psychiatrist;
(8) Psychiatric advanced registered nurse practitioner (ARNP);
(9) Physician assistant working under the supervision of a psychiatrist;
(10) Registered counselor; or
(11) Polygrapher.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0285, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0290 Are there limits to behavior management? The following limits apply to your receipt of behavior management:

(1) DDD and the treating professional will determine the need and amount of service you will receive.

(2) DDD may require a second opinion from a DDD-selected provider.

(3) Only scientifically proven, nonexperimental methods may be utilized.

(4) Providers may not use methods that cause pain, threats, isolation or locked settings.

(5) The need for behavior management must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(6) Psychological testing is not allowed.

(7) Behavior management services require prior approval by the regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0290, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0300 What is parent/sibling education? Parent/sibling education is class training for parents and siblings who have a family member with a developmental disability offering relevant topics. Examples of topics could be coping with family stress, addressing your child's behavior, managing the family's daily schedule or advocating for your child.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0300, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0305 Who are qualified providers for parent/sibling education? (1) The provider of parent/sibling education must be one of the following licensed, registered or certified professionals and be contracted with DDD for the service specified in the ISP:

(a) Audiologist;
(b) Licensed practical nurse;
(c) Marriage and family therapist;
(d) Mental health counselor;
(e) Occupational therapist;
(f) Physical therapist;
(g) Registered nurse;
(h) Sex offender treatment provider;
(i) Speech/language pathologist;
(j) Social worker;
(k) Psychologist;
(l) Certified American sign language instructor;
(m) Nutritionist;
(n) Registered counselor; or
(o) Certified dietician.

(2) Along with these professional providers, the Arc, Parent to Parent, PAVE and Families Together may be utilized for parent/sibling education.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0305, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0308 How is parent/sibling education paid? Parent/sibling education may be a reimbursable expense through the parent family support contract, the pass through contract or directly to the contracted provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0308, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0310 Are there limitations to parent/sibling education? (1) Parent/sibling education does not include conference fees or lodging.

(2) Viewing of VHS or DVD at home by yourself does not meet the definition of parent or sibling education.

(3) The need for parent/sibling education must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(4) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0310, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0315 What are recreational opportunities? (1) Recreational opportunities are activities that may be available to children and adults with a developmental disability such as summer camps, YMCA activities, day trips or typical activities available in your community.

(2) Recreational opportunities may include memberships in civic groups, clubs, crafting classes, or classes outside of K-12 school curriculum or sport activities.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0315, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0320 How are recreational opportunities paid for? Recreational opportunities may be a reimbursable expense through the parent family support contract and the pass through contract.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0320, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0325 Are there limitations to recreation opportunities? (1) The recreational opportunities must occur in your community or the bordering states addressed in WAC 388-832-0331.

(2) The need for recreation opportunities must be identified in your ISP and, in combination with other IFS services, cannot exceed your IFS allocation.

(3) DDD does not pay for recreational opportunities that may pose a risk to individuals with disabilities or the community at large.

(4) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0325, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0330 Does my family have a choice of IFS program services? In collaboration with your case manager and based upon your assessed need, you may choose the services available with this program.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0330, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0331 May I receive IFS program services out-of-state? You may receive IFS program services in a recognized out-of-state bordering city on the same basis as in-state services. The only recognized bordering cities are: Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston Idaho; and Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0331, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0332 Will I have a choice of provider? You may choose a qualified individual, agency or licensed provider within the guidelines described in WAC 388-825-300 through 388-825-400. These WACs describe:

(1) Qualifications for individuals and agencies providing DDD services in the client's residence or the provider's residence or other settings; and

(2) Conditions under which DDD will pay for the services of an individual provider or a home care agency provider or other provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0332, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0333 What restrictions apply to the IFS program services? The following restrictions apply to the IFS program services:

(1) IFS program services are authorized only after you have accessed what is available to you under medicaid, including medicaid personal care, and any other private health insurance plan, school, or child development services.

(2) All IFS program service payments must be agreed to by DDD and you in your ISP.

(3) DDD will contract directly with a service provider or parent for the reimbursement of goods or services purchased by the family member.

(4) DDD will not pay for treatment determined by DSHS/MAA or private insurance to be experimental.

(5) Your choice of qualified providers and services may be limited to the most cost effective option that meets your assessed need.

(6) The IFS program will not pay for services provided after the death of the eligible client. Payment may occur after the date of death, but not the service.

(7) DDD's authorization period will start when you agree to be in the IFS program and have given written or verbal approval for your ISP. The period will last up to one year and may be renewed if you continue to need and utilize services. If you have not utilized the services within one year period you will be terminated from this program.

(8) IFS program will not pay for psychological evaluations or testing, or DNA testing.

(9) Supplies/materials related to community integration or recreational activities are the responsibility of the family.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0333, filed 8/5/08, effective 9/5/08.]

ONE-TIME AWARDS

WAC 388-832-0335 What is a one-time award? One-time awards are payments to individuals and families who meet the IFS program eligibility requirements and have a one

time unmet need not covered by any other sources for which they are eligible. One-time awards can only be used for architectural/vehicular modifications, or specialized equipment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0335, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0340 Who is eligible for a one-time award? You are eligible to be considered for a one-time award if:

(1) You are not currently authorized for IFS program services in your ISP.

(2) You meet the eligibility for the IFS program.

(3) The need is critical to the health or safety of you or your caregiver and you and your family have no other resource to meet the need or your resources do not cover all of the expense.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0340, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0345 Are there limitations to one-time awards? (1) One-time awards are limited to architectural/vehicular modifications or specialized equipment.

(2) One-time awards cannot exceed six thousand dollars in a twenty-four month period.

(3) One-time awards must be approved by the director of DDD or designee.

(4) Eligibility for a one-time award does not guarantee approval and authorization of the service by DDD. Services are based on availability of funding.

(5) One-time awards will be prorated by the number of other members in the household who use these modifications or specialized equipment.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0345, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0350 How do I apply for the one-time award? If you have a need for a one-time award, you can make the request to your case manager.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0350, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0353 Do I need to have a DDD assessment before I receive a one-time award? You need to have a DDD assessment prior to receiving a one-time award.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0353, filed 8/5/08, effective 9/5/08.]

EMERGENCY

WAC 388-832-0355 What is an emergency service? Emergency services are respite care, behavior management or nursing services in response to a single incident, situation or short term crisis.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0355, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0360 What situations qualify for emergency services? The following situations qualify as an emergency:

(1) You lose your family caregiver due to caregiver hospitalization, or death;

(2) There are changes in your caregiver's mental or physical status resulting in your family caregiver's inability to perform effectively for you; or

(3) There are significant changes in your emotional or physical condition that require emergency services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0360, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0365 Who is a qualified provider of emergency services? The provider of the service you need to meet your emergency must meet the provider qualifications required to contract for that specific service per the following:

(1) Respite per WAC 388-832-0155.

(2) Behavior management per WAC 388-832-0285.

(3) Nursing per WAC 388-845-1705.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0365, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0366 What limitations apply to emergency services? (1) Emergency services may be granted to individuals and families who are on the IFS wait list and have an emergent need.

(2) Funds are provided for a limited period not to exceed sixty days.

(3) All requests are reviewed and approved or denied by the regional administrator or designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0366, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0367 What if the client or family situation requires more than sixty days of emergency service? (1) Emergency services are limited to sixty days.

(2) DDD will conduct an administrative review of other DDD services to determine if the need can be met through other services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0367, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0369 Do I need to have a DDD assessment before I receive an emergency service? You do not need to have a DDD assessment prior to receiving an emergency service; however the regional manager/designee may request a DDD assessment for a client at any time.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0369, filed 8/5/08, effective 9/5/08.]

GRANTS

WAC 388-832-0370 What are the IFS community service grants? Community service grants are grants to agencies or individuals funded by the IFS program to promote community oriented projects that benefit families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0370, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0375 How does a proposed project qualify for funding? To qualify for funding, a proposed project must:

(1) Address one or more of the following topics:

(a) Provider support and development;

(b) Parent helping parent; or

(c) Community resource development for inclusion of all.

(2) Meet most of the following goals:

(a) Enable families to use generic resources which are integrated activities and/or resources community members typically have access to;

(b) Reflect geographic, cultural and other local differences;

(c) Support families in a variety of noncrisis-oriented ways;

(d) Prioritize support for unserved families;

(e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;

(f) Be family focused;

(g) Increase inclusion of persons with developmental disabilities;

(h) Benefit families who have children or adults eligible for services from DDD and who do not receive other DDD paid services; and

(i) Promote community collaboration, joint funding, planning and decision making.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0375, filed 8/5/08, effective 9/5/08.]

HEARINGS AND APPEALS

WAC 388-832-0460 How will DDD notify me on their decisions? Your case resource manager will call you and send a written planned action notice per WAC 388-825-100.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0460, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0470 What are my appeal rights under the individual family services program? You have the appeal rights described in WAC 388-825-100 through 388-825-165.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0470, filed 8/5/08, effective 9/5/08.]

Chapter 388-835 WAC

ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-835-010 Terms—Definitions. [99-19-104, recodified as § 388-835-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-001, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-001, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-001, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-001, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-001, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-0135 What are DSHS responsibilities when it decides to transfer a resident? [Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0135, filed 4/20/01, effective 5/21/01.] Repealed by 04-16-018, filed 7/23/04, effective 8/23/04. Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205.

388-835-015 Exemptions. [99-19-104, recodified as § 388-835-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-003, filed 8/9/91, effective 9/9/91.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-020 ICF/MR care. [99-19-104, recodified as § 388-835-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-005, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-005, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-005, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-025 Name of IMR. [99-19-104, recodified as § 388-835-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-015, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-030 Closure of an IMR facility. [99-19-104, recodified as § 388-835-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-020, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-035 Adequate IMR care. [99-19-104, recodified as § 388-835-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-025, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-040 Continuity of resident care. [99-19-104, recodified as § 388-835-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-030, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-045 IMR contract—Noncompliance. [99-19-104, recodified as § 388-835-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order

1853), § 275-38-035, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-050 Minimum staff requirements. [99-19-104, recodified as § 388-835-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-045, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-045, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-055 Placement of client. [99-19-104, recodified as § 388-835-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-050, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-050, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-060 Transfer of client—Relocation. [99-19-104, recodified as § 388-835-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-055, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-055, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-065 Resident rights—Relocation redetermination of eligibility. [99-19-104, recodified as § 388-835-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-060, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-070 Transfer or discharge planning. [99-19-104, recodified as § 388-835-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-065, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-065, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-075 Discharge, readmission, and incident reporting. [99-19-104, recodified as § 388-835-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-075, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-075, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-080 Social leave for IMR residents. [99-19-104, recodified as § 388-835-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-080, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-085 Superintendent's limited authority to hold. [99-19-104, recodified as § 388-835-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-090, filed 8/9/91, effective 9/9/91.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-090 Prospective cost-related reimbursement. [99-19-104, recodified as § 388-835-090, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-510, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-095 Conditions of participation. [99-19-104, recodified as § 388-835-095, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-515, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-100 Projected budget for new contractors. [99-19-104, recodified as § 388-835-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-520, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-520, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-105 Change of ownership. [99-19-104, recodified as § 388-835-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-525, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-525, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-110 Termination of contract. [99-19-104, recodified as § 388-835-110, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-530, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-530, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-115 Due dates for reports. [99-19-104, recodified as § 388-835-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-535, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-535, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-535, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-120 Requests for extensions. [99-19-104, recodified as § 388-835-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-540, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-540, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-125 Reports. [99-19-104, recodified as § 388-835-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-545, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-545, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-130 Failure to submit final reports. [99-19-104, recodified as § 388-835-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-546, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-135 Improperly completed or late reports. [99-19-104, recodified as § 388-835-135, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-550, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-550, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-140 Completing reports and maintaining records. [99-19-104, recodified as § 388-835-140, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-555, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-555, filed 8/21/86; 82-16-080 (Order 1853), § 275-38-555, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-145 Certification requirement. [99-19-104, recodified as § 388-835-145, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-560, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-560, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-150 Reports—False information. [99-19-104, recodified as § 388-835-150, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-565, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-565, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-155 Amendments to reports. [99-19-104, recodified as § 388-835-155, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-570, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-570, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-160 Requirement for retention of reports by the department. [99-19-104, recodified as § 388-835-160, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-585, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-585, filed

8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-165 Requirements for retention of records by the contractor. [99-19-104, recodified as § 388-835-165, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-586, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-170 Disclosure of IMR facility reports. [99-19-104, recodified as § 388-835-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-590, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-175 Desk review. [99-19-104, recodified as § 388-835-175, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-595, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-180 Field audits. [99-19-104, recodified as § 388-835-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-600, filed 6/1/88; 84-09-018 (Order 2091), § 275-38-600, filed 4/10/84; 82-16-080 (Order 1853), § 275-38-600, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-185 Preparation for audit by the contractor. [99-19-104, recodified as § 388-835-185, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-605, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-605, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-190 Scope of field audits. [99-19-104, recodified as § 388-835-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-610, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-610, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-195 Inadequate documentation. [99-19-104, recodified as § 388-835-195, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-615, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-615, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-200 Deadline for completion of audits. [99-19-104, recodified as § 388-835-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-620, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-620, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-205 Disclosure of audit narratives and summaries. [99-19-104, recodified as § 388-835-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-625, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-210 Resident trust accounts. [99-19-104, recodified as § 388-835-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-645, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-215 Accounting procedures for resident trust accounts. [99-19-104, recodified as § 388-835-215, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-650, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-650, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-220 Trust moneys—Imprest fund. [99-19-104, recodified as § 388-835-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-655, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-655, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-225 Trust moneys control or disbursement. [99-19-104, recodified as § 388-835-225, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-660, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-660, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-230 Trust moneys availability. [99-19-104, recodified as § 388-835-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-665, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-235 Accounting upon change of ownership. [99-19-104, recodified as § 388-835-235, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 88-12-087 (Order 2629), § 275-38-667, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-667, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-240 Procedure for refunding trust money. [99-19-104, recodified as § 388-835-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-670, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-245 Liquidation of trust fund. [99-19-104, recodified as § 388-835-245, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-675, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-250 Resident property records. [99-19-104, recodified as § 388-835-250, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 82-16-080 (Order 1853), § 275-38-678, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-255 Allowable costs. [99-19-104, recodified as § 388-835-255, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-680, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-680, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-260 Substance prevails over form. [99-19-104, recodified as § 388-835-260, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-685, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-685, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-265 Offset of miscellaneous revenues. [99-19-104, recodified as § 388-835-265, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-690, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-690, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-270 Costs of meeting standards. [99-19-104, recodified as § 388-835-270, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-695, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-695, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-275 Limit on costs to related organizations. [99-19-104, recodified as § 388-835-275, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-700, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-700, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-280 Start-up costs. [99-19-104, recodified as § 388-835-280, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-705, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-705, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-285 Organization costs. [99-19-104, recodified as § 388-835-285, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-706, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-290 Education and training. [99-19-104, recodified as § 388-835-290, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-715, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-715, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-295 Total compensation—Owners, relatives, and certain administrative personnel. [99-19-104, recodified as § 388-835-295, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-720, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-720, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-300 Owner or relative—Compensation. [99-19-104, recodified as § 388-835-300, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-725, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-725, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-305 Allowable interest. [99-19-104, recodified as § 388-835-305, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-745, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-745, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-745, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-310 Offset of interest income. [99-19-104, recodified as § 388-835-310, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-750, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-750, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-315 Operating leases of facilities and equipment. [99-19-104, recodified as § 388-835-315, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-760, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-320 Rental expense paid to related organizations. [99-19-104, recodified as § 388-835-320, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-765, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-325 Capitalization. [99-19-104, recodified as § 388-835-325, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 90-15-017 (Order 3037), § 275-38-770, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-770, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-770, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-330 Depreciation expense. [99-19-104, recodified as § 388-835-330, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-775, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-775, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-335 Depreciable assets. [99-19-104, recodified as § 388-835-335, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-780, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-780, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-340 Depreciation base. [99-19-104, recodified as § 388-835-340, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-785, filed 6/1/88; 86-01-008 (Order 2312), § 275-38-785, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-785, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-785, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-345 Depreciation base—Donated or inherited assets. [99-19-104, recodified as § 388-835-345, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-790, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-790, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-350 Lives. [99-19-104, recodified as § 388-835-350, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-795, filed 12/5/85; 82-16-080 (Order 1853), § 275-38-795, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-355 Methods of depreciation. [99-19-104, recodified as § 388-835-355, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-800, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-800, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-360 Retirement of depreciable assets. [99-19-104, recodified as § 388-835-360, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-805, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-365 Handling of gains and losses upon retirement of depreciable assets. [99-19-104, recodified as § 388-835-365, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-810, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-370 Handling of gains and losses upon retirement of depreciable assets—Other periods. [99-19-104, recodified as § 388-835-370, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-812, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-812, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-375 Handling of gains and losses upon retirement of depreciable assets. [99-19-104, recodified as § 388-835-375, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-813, filed 12/5/85.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-380 Recovery of excess over straight-line depreciation. [99-19-104, recodified as § 388-835-380, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-815, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-815, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-385 Unallowable costs. [99-19-104, recodified as § 388-835-385, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-820, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-820, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-390 Reimbursement principles. [99-19-104, recodified as § 388-835-390, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-831, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-831, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-831, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-395 Program services not covered by the reimbursement rate. [99-19-104, recodified as § 388-835-395, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-835, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-400 Prospective reimbursement rate for new contractors. [99-19-104, recodified as § 388-835-400, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-840, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-840, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-405 Rate determination. [99-19-104, recodified as § 388-835-405, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-845, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-845, filed 9/17/84; 83-17-074 (Order 2012), §

275-38-845, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-845, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-410 Desk review for rate determination. [99-19-104, recodified as § 388-835-410, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-846, filed 6/1/88; 83-17-074 (Order 2012), § 275-38-846, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-415 Cost centers. [99-19-104, recodified as § 388-835-415, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-850, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-850, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-420 Resident care and habilitation cost center rate. [99-19-104, recodified as § 388-835-420, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-860, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-860, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-860, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-860, filed 8/21/86; 86-01-008 (Order 2312), § 275-38-860, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-860, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-860, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-860, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-860, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-425 Administration, operations, and property cost center rate. [99-19-104, recodified as § 388-835-425, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-863, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-863, filed 3/6/85.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-430 Food rate component. [99-19-104, recodified as § 388-835-430, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-865, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-865, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-865, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-865, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-435 Maximum allowable compensation of certain administrative personnel. [99-19-104, recodified as § 388-835-435, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 84-19-042 (Order 2150), § 275-38-868, filed 9/17/84. Formerly WAC 275-38-730.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-440 Management agreements, management fees, central office services, and board of directors. [99-19-104, recodified as § 388-835-440, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-869, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-869, filed 9/17/84. Formerly WAC 275-38-740.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-445 Administration and operations rate component. [99-19-104, recodified as § 388-835-445, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-870, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-870, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-870, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-870, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-450 Property rate component. [99-19-104, recodified as § 388-835-450, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-875, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-875, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-875, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-875, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-875, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-455 Return on equity. [99-19-104, recodified as § 388-835-455, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-880, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-880, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-880, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-880, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-460 Upper limits to reimbursement rate. [99-19-104, recodified as § 388-835-460, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-885, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-465 Principles of settlement. [99-19-104, recodified as § 388-835-465, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-886, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-886, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-886, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-886, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-470 Procedures for overpayments and underpayments. [99-19-104, recodified as § 388-835-470, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-887, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-475 Preliminary settlement. [99-19-104, recodified as § 388-835-475, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-888, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-480 Final settlement. [99-19-104, recodified as § 388-835-480, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-889, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-485 Interim rate. [99-19-104, recodified as § 388-835-485, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-890, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-890, filed 9/17/84.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-490 Final payment. [99-19-104, recodified as § 388-835-490, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-892, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-892, filed 9/17/84.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-495 Notification of rates. [99-19-104, recodified as § 388-835-495, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-895, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-500 Adjustments required due to errors or omissions. [99-19-104, recodified as § 388-835-500, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-900, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-900, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-505 Receivership. [99-19-104, recodified as § 388-835-505, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-903, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-510 Adjustments to prospective rates. [99-19-104, recodified as § 388-835-510, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-906, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-906, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-906, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

388-835-515	Public review of rate-setting methods and standards. [99-19-104, recodified as § 388-835-515, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.1-20. 82-16-080 (Order 1853), § 275-38-910, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-520	Public disclosure of rate-setting methodology. [99-19-104, recodified as § 388-835-520, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-915, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-525	Billing period. [99-19-104, recodified as § 388-835-525, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-920, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-530	Billing procedures. [99-19-104, recodified as § 388-835-530, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-925, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-925, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-535	Charges to residents. [99-19-104, recodified as § 388-835-535, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-930, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-540	Payment. [99-19-104, recodified as § 388-835-540, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-935, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-545	Suspension of payment. [99-19-104, recodified as § 388-835-545, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-940, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-940, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-550	Termination of payments. [99-19-104, recodified as § 388-835-550, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-945, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-945, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-555	Disputes. [99-19-104, recodified as § 388-835-555, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-950, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-560	Recoupment of undisputed overpayments. [99-19-104, recodified as § 388-835-560, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-955, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-955, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-565	Administrative review—Adjudicative proceeding. [99-19-104, recodified as § 388-835-565, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-38-960, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-960, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-960, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

PURPOSE

WAC 388-835-0005 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules authorized by Title 71A RCW, Developmental disabilities that:

(a) Regulate the purchase and provision of services in intermediate care facility for the mentally retarded (ICF/MR); and

(b) Assure adequate ICF/MR care, service, and protection are provided through licensing and certification procedures; and

(c) Establish standards for providing habilitative training, health-related care, supervision, and residential services to eligible persons.

(2) Except where specifically referenced, this chapter supersedes and replaces any and all sections affecting ICF/MR facilities or programs contained in chapter 388-96 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0005, filed 4/20/01, effective 5/21/01.]

DEFINITIONS

WAC 388-835-0010 What terms and definitions are important to understanding this chapter? Unless the context clearly requires otherwise, the following terms and definitions are used consistently throughout the chapter:

"Accrual method of accounting" is a method of accounting where:

(1) Revenues are reported when they are earned, regardless of when they are collected; and

(2) Expenses are reported when they are incurred, regardless of when they are paid.

"Active treatment," as used in this chapter, is defined in 42 CFR 483.440(a) and includes implementation of an individual program plan for each resident as outlined in 42 CFR 483.440 (c) through (f).

"Administration and management" means activities used to maintain, control, and evaluate an organization's use of resources while pursuing its goals, objectives and policies.

"Admission" means entering a state-certified facility and being authorized to receive services from it.

"Allowable costs" are documented costs that:

(1) Are necessary, ordinary, and related to providing ICF/MR services to ICF/MR residents; and

(2) Not expressly declared **"nonallowable"** by applicable statutes or regulations.

"Appraisal" is a process performed by a professional person either designated by the American Institute of Real Estate Appraisers as a member, appraisal institute (MAI), or by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA). The appraisal process is used to establish the fair market value of an asset or to reconstruct the historical cost of an asset that was acquired in a past period. The appraisal process includes recording and analyzing property facts, rights, investments and values based on a personal inspection and a property inventory.

"Arm's-length transaction" is a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions. A sale or exchange of ICF/MR or nursing home facilities among two or more parties where all parties continue to own one or more of the facilities involved in the transaction is not considered an arm's-length transactions. The sale of an ICF/MR facility that is subsequently leased back to the seller within

five years of the date of sale is not considered an arm's-length transaction for purposes of chapter 388-835 WAC.

"Assets" are economic resources of the provider, recognized, and measured in conformity with generally accepted accounting principles. Assets also include deferred charges that are recognized and measured according to generally accepted accounting principles. (The value of assets acquired in a change of ownership transaction entered into after September 30, 1984, cannot exceed the acquisition cost of the owner of record as of July 18, 1984.)

"Bad debts" or **"uncollectable accounts"** are amounts considered uncollectable from accounts and notes receivable. Generally accepted accounting principles must be followed when accounting for bad debts.

"Beds," unless otherwise specified, means the number of set-up beds in an ICF/MR facility. The number of set-up beds cannot exceed the number of licensed beds for the facility.

"Beneficial owner": For a definition, see WAC 388-835-0015.

"Boarding home" means any home or other institution licensed according to the requirements of chapter 18.20 RCW.

"Capitalization" means recording expenditures as assets.

"Capitalized lease" is a lease that is recorded, according to generally accepted accounting principles, as an asset with an associated liability.

"Cash method of accounting" is a method of accounting where revenues are recorded only when cash is received and expenses are not recorded until cash is paid.

"Change of ownership," see WAC 388-835-0020.

"Charity allowances" are reductions in a provider's charges because of the indigence or medical indigence of a resident.

"Consent" means the process of obtaining a person's permission before initiating procedures or actions against that person.

"Contract" means a contract between the department and a provider for the delivery of ICF/MR services to eligible medicaid recipients.

"Provider" means an entity contracting with the department to deliver ICF/MR services to eligible medicaid recipients.

"Courtesy allowances" are reductions in charges to physicians, clergy, and others for services received from a provider. Employee fringe benefits are not considered courtesy allowances.

"Custody" means the immediate physical confinement, sheltering and supervision of a person in order to provide them with care and protect their welfare.

"DDD" means the division of developmental disabilities of the department.

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

"Depreciation" is the systematic distribution of the cost (or depreciable base) of a tangible asset over its estimated useful life.

"Discharge" means the process that takes place when:

(1) A resident leaves a residential facility; and

(2) The facility relinquishes any responsibility it acquired when the resident was admitted.

"Donated asset" is an asset given to a provider without any payment in cash, property, or services. An asset is not considered donated if the provider makes a nominal payment when acquiring it. An asset purchased using donated funds is not a donated asset.

"Entity" means an individual, partnership, corporation, public institution established by law, or any other association of individuals, capable of entering into enforceable contracts.

"Equity capital" is the total tangible and other assets that are necessary, ordinary, and related to resident care listed on a provider's most recent cost report minus the total related long-term debt from the same cost report plus working capital as defined in this section.

"Exemption" means a department approved written request asking for an exception to a rule in this chapter.

"Facility" means a residential setting certified, according to federal regulations, as an ICF/MR by the department. A state facility is a state-owned and operated residential living center. A private facility is a residential setting licensed as a nursing home under chapter 18.51 RCW or a boarding home licensed under chapter 18.20 RCW.

"Fair market value" is the purchase price of an asset resulting from an arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

"Financial statements" are statements prepared and presented according to generally accepted accounting principles and practice and the requirements of this chapter. Financial statements and their related notes include, but are not limited to, balance sheet, statement of operations, and statement of change in financial position.

"Fiscal year" is the operating or business year of a provider. Providers report on the basis of a twelve-month fiscal year, but this chapter allows reports covering abbreviated fiscal periods.

"Funded capacity," for a state facility, is the number of beds on file with the office of financial management.

"Generally accepted accounting principles" are the accounting principles currently approved by the financial accounting standard board (FASB).

"Generally accepted auditing standards" are the auditing standards currently approved by the American Institute of Certified Public Accountants (AICPA).

"Goodwill" is the excess of the purchase price of a business over the fair market value of all identifiable, tangible, and intangible assets acquired. **"Goodwill"** also means the excess of the price paid for an asset over fair market value.

"Habilitative services" means those services required by an individual habilitation plan.

"Harmful" is when an individual is at immediate risk of serious bodily harm.

"Historical cost" is the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

"Imprest fund" is a fund:

(1) Regularly replenished for the amounts expended from it; and

(2) The cash in the fund and the receipts for expenditures should always equal a predetermined amount.

(3) An example of an imprest fund is a petty cash fund.

"ICF/MR" means a facility certified by Title XIX as an intermediate care facility for providing services to persons with mental retardation or related conditions.

"Interest" is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the borrower.

"Joint facility costs" are any expenses incurred that benefit more than one facility or a facility and any other entity.

"Lease agreement" is a contract for a specified period of time between two parties regarding the possession and use of real or personal property and/or assets in exchange for specified periodic payments.

"Medicaid program" means either the state medical assistance program provided under RCW 74.09.500 or authorized state medical services.

"Medical assistance recipient" is an individual that the department declares eligible for medical assistance services provided in chapter 74.09 RCW.

"Modified accrual method of accounting" is a method of accounting that records revenues only when cash is received and records expenses when they are incurred, regardless of when they are paid.

"Net book value" is the historical cost of an asset less its accumulated depreciation.

"Nonallowable costs" are costs that are not documented, necessary, ordinary and related to providing services to residents.

"Nonrestricted funds" are donated funds not restricted to a specific use by the donor. General operating funds are an example of nonrestricted funds.

"Nursing facility" means a home, place, or institution, licensed or certified according to chapter 18.51 RCW.

"Operating lease" is a lease, according to generally accepted accounting principles, that requires rental or lease payments to be charged to current expenses when they are incurred.

"Ordinary costs" are costs that, by their nature and magnitude, a prudent and cost conscious management would pay.

"Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of at least five percent of a corporation's outstanding stock.

"Ownership interest" means all beneficial interests owned by a person (calculated in the aggregate) regardless of the form such beneficial ownership takes. Also, see WAC 388-835-0015.

"Per diem costs" or **"per resident day costs"** are total allowable costs for a fiscal period divided by total resident days for that same period.

"Prospective daily payment rate" is the daily amount the department assigns to each provider for providing services to ICF/MR residents. The rate is used to compute the department's maximum participation in the provider's cost.

"Qualified mental retardation professional (QMRP)" means QMRP as defined under 42 CFR 483.430 (a).

"Qualified therapist," see WAC 388-835-0030.

"Regression analysis" is a statistical technique used to analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

"Regional services" are the services of a local office of the division of developmental disabilities.

"Related organization" is an entity that either controls another entity or is controlled by another entity or provider. Control results from common ownership or the ability to exercise significant influence on the other entity's activities. Control occurs when an entity or provider has:

(1) At least a five percent ownership interest in the other entity; or

(2) The ability to influence the activities of the other.

"Relative" means spouse; natural parent, child, or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; uncle, aunt, nephew, niece, or cousin.

"Resident" or **"person"** means a person the division determines is, under RCW 71A.16.040 eligible for division-funded services.

"Resident day" means a calendar day of resident care. When computing calendar days of resident care, the day of admission is always counted. The day of discharge is counted only when discharge and admission occur on the same day. For the purpose of this definition, a person is considered admitted when they are assigned a bed and a resident record is opened for them.

"Resident care and training staff" are staff whose primary responsibility is the care and development of the residents, including:

(1) Resident activity program;

(2) Domiciliary services; and

(3) Habilitative services under the supervision of a QMRP.

"Restricted fund" is a fund where the donor restricts the use of the fund principal or income to a specific purpose. Restricted funds generally fall into one of three categories:

(1) Funds restricted to specific operating purposes; or

(2) Funds restricted to additions of property, plant, and equipment; or

(3) Endowment funds.

"RHC" - Residential habilitation center. A facility owned and operated by the state and is certified as an ICF/MR or a nursing facility.

"Secretary" means the secretary of DSHS.

"Start-up costs" are the one-time costs incurred from the time preparations begin on a newly constructed or purchased building until the first resident is admitted. Such **"preopening"** costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, and training costs. Start-up costs do not include expenditures for capital assets.

"Superintendent" means the superintendent of a residential habilitation center (RHC) or the superintendent's designee.

"Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

"Uniform chart of accounts" means a list of department established account titles and related code numbers that providers must use when reporting costs.

"Vendor number" or **"provider number"** is a number assigned by the department to each provider who delivers ICF/MR services to ICF/MR medicaid recipients.

"Working capital" is the difference between the total current assets that are necessary, ordinary, and related to resident care, as reported in a provider's most recent cost report, and the total current liabilities necessary, ordinary, and related to resident care reported in the same cost report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0010, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0015 What is a "beneficial owner"? A beneficial owner is any person who:

(1) Has or shares, by contract, arrangement, understanding, relationship, or otherwise, the power to:

(a) Vote or direct the voting of an ownership interest; and/or

(b) Invest, including the power to dispose of or direct the disposition of an ownership interest.

(2) Creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device to divest a beneficial owner of their ownership or prevent the vesting of their ownership in order to evade the reporting requirements of this chapter;

(3) Has the right to acquire a beneficial ownership interest within sixty days of one of the following occurring:

(a) Exercising any option, warrant, or right;

(b) Converting an ownership interest;

(c) Revoking a trust, discretionary account, or similar arrangement; or

(d) Automatically terminating a trust, discretionary account, or similar arrangement.

(e) Any person acquiring an ownership interest by exercising (a), (b) or (c) of this subsection must be deemed the beneficial owner of that interest.

(4) In the ordinary course of business, according to a written pledge agreement, becomes a pledge of an ownership interest. A pledge must not be deemed the beneficial owner of a pledged ownership interest except when all of the following conditions are met:

(a) The pledge must follow all the steps in the pledge agreement and:

(i) Declare a default and determine the power to vote;

(ii) Direct the vote; or

(iii) Dispose of the pledged ownership interest; or

(iv) Direct how the disposition of the pledged ownership interest will take place.

(b) The agreement must:

(i) Be bona fide;

(ii) Not change or influence a provider's control; and

(iii) Not be related to any transaction attempting to change or influence a provider's control.

(c) The agreement, before default, cannot grant the pledge the power to:

(i) Vote or direct the vote of the pledged ownership interest; or

(ii) Dispose or direct the disposition of the pledged ownership interest except where credit is extended and the pledge is a broker or dealer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0015, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0020 What is a "change in ownership"? (1) A "change in ownership" is a change in the individual or legal organization responsible for the daily operation of an ICF/MR facility.

(2) Types of events causing a change in ownership include but are not limited to:

(a) Changing the form of legal organization of the owner, such as a sole proprietorship becomes a partnership or corporation;

(b) Transferring the title to the ICF/MR enterprise from the provider to another party;

(c) Leasing the ICF/MR facility to another party or an existing lease is terminated;

(d) When the provider is a partnership, any event that dissolves the partnership;

(e) When the provider 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 other corporations to form a new corporation.

(3) Ownership does not change when:

(a) The provider contracts with another party to manage the facility and act as the provider's agent subject to the provider's general approval of daily operating decisions; or

(b) When the provider is a corporation, some or all of its corporate stock is transferred.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0020, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0025 How can lease agreements be terminated? (1) Lease agreements can be terminated by:

(a) Eliminating or adding parties to the agreement;

(b) Expiration of the agreement;

(c) Modifying of any lease term in the agreement;

(d) Terminating the agreement by any means by either party; or

(e) Extending or renewing the agreement, even if done according to its renewal provision, creates a new agreement and effectively terminates the old one.

(2) A strictly formal change in a lease agreement modifying the method, frequency, or manner in which lease payments are made without increasing the total payment obligation of the lessee is not considered a modification of the lease terms.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0025, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0030 What is a "qualified therapist"? A qualified therapist is any of the following:

(1) An activity specialist who has department specified specialized education, training, or experience;

(2) An audiologist eligible for a certificate of clinical competency in audiology or possessing the equivalent education and clinical experience;

(3) A dental hygienist defined, licensed and regulated by chapter 18.29 RCW;

(4) A dietitian either:

(a) Eligible for registration by the American Dietetic Association under requirements in effect on January 17, 1974; or

(b) With a baccalaureate degree whose major studies covered food and nutrition, dietetics, or food service management; plus one year supervisory experience in the dietetic service of a health care institution; and annual participation in continuing dietetic education;

(5) An occupational therapist who graduated from a program in occupational therapy or who possesses the equivalent of such education or training and meets all Washington state legal requirements;

(6) A pharmacist who is licensed by the Washington state board of pharmacy to engage in the practice of pharmacy;

(7) A physical therapist, meaning someone practicing physical therapy as defined in RCW 18.74.010(3). Physical therapist does not include massage operators as defined in RCW 18.108.010;

(8) A physician as defined, licensed and regulated by chapter 18.71 RCW or an osteopathic physician as defined, licensed and regulated by chapter 18.57 RCW;

(9) A psychologist as defined, licensed and regulated by chapter 18.83 RCW;

(10) A qualified mental retardation professional;

(11) A registered nurse as defined by chapter 18.88A RCW;

(12) A social worker who is a graduate of a school of social work; or

(13) A speech pathologist either:

(a) Eligible for a certificate of clinical competence in speech pathology; or

(b) Possessing the equivalent education and clinical experience.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0030, filed 4/20/01, effective 5/21/01.]

EXEMPTIONS

WAC 388-835-0035 Does DSHS grant exemptions to these rules? (1) DSHS may approve an exemption to a specific rule in this chapter if an:

(a) Assessment of the request concludes that the exemption will not undermine the legislative intent of Title 71A RCW, Developmental disabilities; and

(b) Evaluation of the request shows that the exemption will not adversely effect the quality of service, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers must retain a copy of each department-approved exemption.

(3) Actions regarding exemption requests are not subject to appeal.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0035, filed 4/20/01, effective 5/21/01.]

GENERAL REQUIREMENTS

WAC 388-835-0040 What general requirements apply to ICF/MR care facilities? The following general requirements apply:

(1) The division will recognize only the official name of an ICF/MR as shown on the license.

(2) All state and private ICF/MR facilities must be certified as a Title XIX IMR ICF/MR facility.

(3) All private ICF/MR facilities with a certified capacity of at least sixteen beds must be licensed as a nursing home under chapter 18.51 RCW, Nursing homes.

(4) All private ICF/MR facilities with a certified capacity of less than sixteen beds must be licensed as a boarding home for the aged under chapter 18.20 RCW.

(5) All facilities certified to provide ICF/MR services must comply with all applicable Title XIX, Section 1905 of the Social Security Act 42 U.S.C federal regulations as amended. In addition, all private-operated facilities must comply with state regulation governing the licensing of nursing homes or boarding homes for the aged and any other relevant state regulations.

(6) All certified facilities must only admit persons with developmental disabilities as residents.

(7) State facilities may not exceed funded capacity unless authorized by the secretary to do so (see RCW 71A.20.090).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0040, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0045 What are the minimum staff requirements for an ICF/MR facility? All ICF/MR facilities must provide sufficient number of qualified staff to meet the needs of their residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0045, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0050 What general requirements apply to the quality of ICF/MR services? (1) DSHS is responsible for assuring the:

(a) Health care and habilitative training needs of an individual are identified and met according to state and federal regulations.

(b) Individual is placed in a facility certified as capable of meeting their needs.

(2) DDD regional service staff is responsible for authorizing changes in residential services.

(3) All services provided must be essential to the resident's habilitation and health care needs and to achieving the primary goal of attaining the highest level of independence possible for each individual resident.

(4) A resident in an ICF/MR is eligible for community residential services when such services meet their needs.

(5) Every ICF/MR must provide habilitative training and health care that at least includes the following:

(a) Active treatment;

(b) Services according to the identified needs of the individual resident and provided by or under the supervision of qualified therapists;

(c) Routine items and supplies provided uniformly to all residents;

(d) Providing necessary surgical appliances, prosthetic devices, and aids to mobility for the exclusive use of individual residents;

(e) Nonreusable supplies not usually provided to all residents may be individually ordered. A department representative must authorize requests for such supplies.

(6) Each ICF/MR facility is responsible for providing transportation for residents. This responsibility may include the guarantee of a resident's use of public transportation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0050, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0055 What are the resident's rights if DSHS decides that they are no longer eligible for ICF/MR services? (1) A resident, their guardian, next-of-kin, or responsible party must be informed by DSHS in writing thirty days before any redetermination of their eligibility for ICF/MR services takes place.

(2) The redetermination notice must include:

(a) The reasons for the proposed eligibility change;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within thirty days of receipt of the notice;

(c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;

(d) Information as to how a hearing can be requested;

(e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and

(f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0055, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0060 What are DSHS responsibilities when it decides to redetermine a resident eligibility for ICF/MR services? DSHS must send a hearing request form with the notice of redetermination.

(1) If the resident requests a hearing within the thirty-day time period, DSHS must not redetermine eligibility until a hearing decision is reached or appeal rights have been exhausted unless redetermination is warranted by the resident's health or safety needs.

(2) If the secretary or the secretary's designee concludes that redetermination is not appropriate, no further action will be taken to redetermine eligibility unless there is a change in the situation or circumstances. If there is a change in the situation or circumstances, the request may be resubmitted.

(3) If the secretary or the secretary's designee affirms the decision to change the resident's eligibility and no judicial review is filed within thirty days of the receipt of notice of redetermination, the department must proceed with the planned action.

(4) If the secretary or secretary's designee affirms the decision to change the resident's eligibility and a request for judicial review has been filed, any proposed redetermination must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0060, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0065 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department concludes that the facility where the resident resides cannot provide Title XIX services due to:

(1) Termination of the facility's contract;

(2) Decertification of the facility;

(3) Nonrenewal of the facility's contract;

(4) Revocation of the facility's license; or

(5) An emergency suspension of the facility's license.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0065, filed 4/20/01, effective 5/21/01.]

PLACEMENT—TRANSFER—RELOCATION—DISCHARGE

WAC 388-835-0070 What requirements apply to the placement of individuals in an ICF/MR facility? (1) Placing individuals in an ICF/MR facility is the responsibility of the division of developmental disabilities and must be done according to applicable federal and state regulations.

(2) A facility may not admit an individual who requires services the facility cannot provide.

(3) Department representatives must determine an individual's eligibility for ICF/MR services before payment can be approved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0070, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0075 What if an individual is transferred between facilities? (1) When an individual is transferred between facilities, all essential information concerning the individual, their condition, regimen of care and training must be transmitted, in writing, by the sending facility to the receiving facility at the time of the transfer.

(2) "Transferred between facilities" means transferred from:

(a) An ICF/MR to ICF/MR;

(b) An ICF/MR to a hospital;

(c) A hospital to an ICF/MR; or

(d) An ICF/MR or hospital to alternative community placement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0075, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0080 What if an ICF/MR facility is closed? (1) When a facility plans to close, it must notify the department, in writing, at least one hundred and eighty days before the date of closure.

(2) Upon receipt of a notice of closure, the department must stop referring individuals to the facility and begin the orderly transfer of its residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0080, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0085 Why is an individual transferred or discharged? An individual admitted to a facility can be transferred or discharged only for:

(1) Medical reasons;

(2) A change in the individual's habilitation needs;

(3) The individual's welfare;

(4) The welfare of other residents;

(5) At the request of the resident or legal guardian;

(6) Partial closure of the facility; or

(7) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0085, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0085, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0090 What is the basis of the decision to transfer or discharge an individual? The decision to transfer or discharge an individual must be based on:

(1) An assessment of the resident in consultation with the service provider and the parent or guardian; and

(2) A review of the relevant records; or

(3) Partial closure of the facility; or

(4) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0090, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0090, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0095 Is a transfer plan required for each resident? (1) DDD must prepare a written plan for each resident to be transferred.

(2) These plans must:

(a) Identify the location of available facilities that provide services appropriate and consistent with the resident's needs;

(b) Provide for coordination between the staffs of the old and new agencies;

(c) Allow for a pre-transfer visit, when the resident's condition permits, to the new facility, so the resident can become familiar with the new surroundings and residents;

(d) Encourage active participation by the resident's guardian or family in the transfer preparation;

(e) Facilitate discussions between the staffs of the old and new facilities regarding expectations;

(f) Provide opportunities for consultations on request between the two staffs; and

(g) Require follow-up by DDD to monitor the effects of the transfer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0095, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0100 Why would an individual move? An individual may move if:

(1) The services provided to an individual do not meet their needs;

(2) A facility's ICF/MR certification or license is revoked or suspended;

(3) Medical reasons dictate relocation;

(4) A resident's welfare would be improved;

(5) The welfare of the other residents would be enhanced;

(6) There is no payment for services provided to the resident during their stay at the facility;

(7) The resident and/or guardian make a formal request;

(8) The facility is partially closing; or

(9) The facility is closing.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0100, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0100, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0105 What are DSHS' responsibilities for placing individuals? (1) When services available to an individual do not meet their needs, the department is responsible for initiating and facilitating the resident's relocation.

(2) The department may enforce immediate movement of a resident from an ICF/MR facility when the facility's ICF/MR certification or license is revoked or suspended.

(3) The department must notify a resident and their guardian, next of kin, or responsible party, in writing, when:

(a) DSHS or Health Care Financing Administration (HCFA) determines a facility no longer meets certification requirements as an ICF/MR;

(b) DSHS determines the facility does not meet contract requirements; or

(c) A facility voluntarily terminates their contract with DSHS or stops participating in the ICF/MR program.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0105, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0110 Is DSHS required to give written notice when it intends to transfer an individual? (1) WAC 388-835-0055 requires that DSHS give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of its intent to transfer the resident.

(2) If there is a serious and immediate threat to the resident's health or safety, DSHS is not required to give the resident and their guardian, next of kin, or responsible party thirty days notice of it's intent to transfer the resident.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0110, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0110, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0115 Can a facility request that an individual be transferred? Facilities can request that a resident be transferred for the following reasons:

(1) Medical reasons;

(2) A change in the individual's habilitation needs;

(3) The individual's welfare;

(4) The welfare of the other residents;

(5) Nonpayment for services provided to the resident during the resident's stay at the facility;

(6) The facility is partially closing; or

(7) The facility is closing.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0115, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0115, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0120 What steps must be followed when a facility makes a transfer request? The following steps apply when a facility wants a resident transferred:

(1) The facility must send their request to the department in writing. The request must explain why the relocation is necessary and document that the interdisciplinary team responsible for developing the resident's habilitation plans agrees with the request.

(2) DSHS must approve or deny the request within fifteen working days of receiving it. The department's decision must be based upon:

(a) An on-site visit with the resident; and

(b) A review of the resident's records.

(3) The facility administrator must be informed of the department's decision.

(4) If the facility's request is approved, the department must give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of it's intent to transfer the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0120, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0125 Can residents request a transfer? (1) Every resident has a right to:

(a) Request a transfer; and

(b) Select where they wish to move.

(2) If the resident's selection is available and appropriate to their habilitation and health care needs, the department must make all reasonable attempts to accomplish transfer.

(3) If the selection is neither appropriate nor available, the resident may make another selection.

(4) All requests by the resident or their guardian must be in writing.

(5) DDD is solely responsible for arranging the resident's transfer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0125, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0130 What rights are available to a resident regarding a proposed transfer? (1) A resident, their guardian, next-of-kin, or responsible party must be notified in writing at least thirty days before any transfer occurs.

(2) The transfer notice must include:

(a) The reasons supporting the proposed transfer;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within twenty-eight days of receipt of the notice;

(c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;

(d) Information as to how a hearing can be requested;

(e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and

(f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0130, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0140 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department concludes that the facility where the resident resides cannot provide Title XIX services due to:

(1) Termination of the facility's contract;

(2) Decertification of the facility;

(3) Nonrenewal of the facility's contract;

(4) Revocation of the facility's license;

(5) An emergency suspension of the facility's license;

(6) Partial closure of the facility; or

(7) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205 04-16-018, § 388-835-0140, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0140, filed 4/20/01, effective 5/21/01.]

DISCHARGE/READMISSION AND INCIDENT REPORTING

WAC 388-835-0145 Does a facility have a responsibility to report incidents involving residents? Any facility that has an ICF/MR contract with DSHS must immediately contact their DDD regional services office regarding unauthorized leaves, disappearances, serious accidents, or other traumatic incidents effecting a resident or the resident's health or welfare.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0145, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0150 When does DSHS require discharge and readmission of a resident? DSHS requires discharge and readmission for all residents admitted as hospital inpatients.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0150, filed 4/20/01, effective 5/21/01.]

SOCIAL LEAVE FOR ICF/MR RESIDENTS

WAC 388-835-0155 What requirements apply to social leaves for ICF/MR residents? (1) All social leaves should be consistent with the goals and objectives in the resident's individual habilitation plan.

(2) Any facility vacancies resulting from a resident's social leave will be reimbursed if the leave complies with the individual habilitation plan and the following conditions:

(a) The facility must notify the DDD director or their designee of all social leaves exceeding fifty-three hours.

(b) All social leaves exceeding seven consecutive days must receive prior written approval from the DDD director or their designee.

(c) The DDD director or their designee must give written approval before a resident can accumulate more than seventeen days of social leave per year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0155, filed 4/20/01, effective 5/21/01.]

SUPERINTENDENT'S AUTHORITY TO DETAIN A RESIDENT

WAC 388-835-0160 Can residential habilitation center (RHC) superintendents involuntarily detain residents? (1) When an RHC resident decides to initiate a voluntarily discharge, the superintendent must determine if the discharge is harmful to the resident.

(2) If the superintendent concludes that the discharge is harmful, they may detain the resident for up to forty-eight hours until the harm passes. The superintendent may also refer the resident to a mental health professional as defined in RCW 71.05.150.

(3) At the end of the forty-eight hour detention period, the superintendent must release the resident.

(4) If, within six months, the superintendent detains the resident a second time, they must refer the resident to a mental health professional within eight hours of the second detention. During this second detention, the resident may only be held until the mental health professional:

(a) Investigates and evaluates the specific facts surrounding the situation; and

(b) Determines if further detention is necessary (see RCW 71.05.150).

(5) Nothing in this section prevents a superintendent or their designee from allowing a resident to leave the RHC for specified periods necessary for their habilitation or care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0160, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0165 Is a superintendent required to give notice when they detain a resident? (1) When a superintendent detains an RHC resident, the superintendent or their designee must notify the resident and their legal representative as required in RCW 71A.10.070.

(2) If the resident's legal representative is not available, the superintendent must also notify one or more of the following persons in the order of priority listed:

(a) A parent of the resident;

(b) Other persons of close kinship relationship to the resident;

(c) The Washington protection and advocacy agency for the rights of a person with a developmental disability, appointed in compliance with 42 USC section 6042; or

(d) A person, who is not a DSHS employee or an ICF/MR but who, in the superintendent's opinion, is concerned with the resident's welfare.

(3) Nothing in this section prevents a superintendent from notifying:

(a) A mental health professional;

(b) Local law enforcement;

(c) Adult protective services;

(d) Child protective services;

(e) Other agencies as appropriate; or

(f) Director, division of developmental disabilities, or designee.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0165, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0170 What is a superintendent's responsibility when a resident voluntarily leaves an RHC? When a resident voluntarily leaves RHC programs and services, the superintendent must initiate discharge proceedings.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0170, filed 4/20/01, effective 5/21/01.]

ICR/MR CONTRACTS

WAC 388-835-0175 What if a facility violates its ICF/MR contract? (1) If a facility violates the terms of their contract, DSHS may temporarily suspend referring residents to it.

(2) Whenever DSHS suspends referrals it must notify the facility immediately, in writing, and give the reasons for its action.

(3) The suspension may continue until DSHS determines that the circumstances leading to it have been corrected.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0175, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0180 What if an ICF/MR contract is terminated? (1) Before a contract is terminated, the provider must give DSHS one hundred and eighty days written notice of the termination.

(2) When a contract is terminated, the provider must submit final reports to DSHS according to the requirements of WAC 388-835-0185.

(3) When notified of a contract termination, DSHS must determine, by preliminary or final settlement calculations, the amount of any overpayments made to the provider, including overpayments disputed by the provider. If preliminary or final settlements are not available for any periods before the termination date of the contract, DSHS must use available relevant information to make a reasonable estimate of any overpayments or underpayments.

(4) The provider must file a properly completed final cost report (see the requirements in WAC 388-835-0225, 388-835-0230, and 388-835-0235). This report may be audited by DSHS. A final settlement must be determined within ninety days after the audit process is completed (including any administrative review of the audit requested by the provider) or within twelve months of the termination of the contract if an audit is not performed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0180, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0180, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0185 Does DSHS withhold payment for services when a contract is terminated? (1) Payment for services provided before a contract was terminated, equal to the amount determined in WAC 388-835-0180(3), may be withheld by DSHS until the provider files a properly completed final annual cost report and a final settlement has been calculated.

(2) Instead of withholding payments, DSHS may allow a provider to offer security equal to the determined and/or estimated overpayments even when the overpayments are being disputed in good faith. Types of security acceptable to DSHS are:

(a) A surety bond issued by a bonding company acceptable to DSHS;

(b) An assignment of funds to DSHS;

(c) Collateral acceptable to DSHS;

(d) A purchaser's assumption of liability for the provider's overpayment; or

(e) Any combination of (a) through (d) of this subsection.

(3) DSHS must release any payments withheld if a provider gives acceptable security equal to the determined and/or estimated overpayments.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0185, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0190 What happens to withheld payments and security from a provider when a final settlement is determined? (1) When a final settlement is determined, security held by DSHS must be released to the provider after any related overpayments owed to the department have been paid.

(2) If the provider disagrees with the settlement and does not repay any overpayments owed, DSHS must retain security equal to the amount of the disputed overpayments until the administrative appeal process is completed.

(3) If the total of withheld payments, bonds, and assignments is less than the total of the determined and/or estimated overpayments, the unsecured portion of the overpayments is a debt owed to the state of Washington. This debt becomes a lien against the provider's real and personal property when DSHS files with the auditor in the county where the provider resides or owns property. This lien has preference over all unsecured creditor claims against the provider.

(4) If the total existing overpayments exceed the value of the security held by DSHS, DSHS may use whatever legal means are available to recover the difference.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0190, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0195 What requirements apply to surety bonds or assigned funds used as security by a provider? All surety bonds or assignment of funds, offered as security, must be:

(1) At least equal in amount to the determined and/or estimated overpayments minus any withheld payments even if the overpayments are the subject of a good faith dispute;

(2) Issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;

(3) For a term sufficient to cover the time period needed to determine a final settlement and exhaust administrative and judicial remedies;

(4) Forfeited to DSHS if the term proves insufficient and the bond or assignment is not renewed for an amount equal to any remaining overpayment in dispute;

(5) Paid to DSHS if a properly completed final cost report is not filed by the provider or if financial records supporting this report are not retained and available to the auditor; and

(6) Paid to DSHS if the provider does not pay the refund owed within sixty days following receipt of a written demand to do so or the conclusion of any administrative or judicial proceedings held to settle the dispute.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0195, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0200 Does decertification, termination or nonrenewal of a contract stop payment of Title XIX funds? A decertification, termination, or nonrenewal of a contract stops the payment of Title XIX funds. Actions such as these do not affect a facility's right to operate as a nursing home or boarding home, but they do disqualify the facility from operating as an ICF/MR facility and receiving federal funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0200, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0205 How does a change in ownership affect an ICF/MR contract with DSHS? (1) On the effective date of a change of ownership, DSHS's contract with the former owner is terminated. The former owner must give DSHS one hundred and eighty days written notice before the contract is terminated. When a certificate of need is required for the new owner and the new owner wishes to continue to provide services to residents without interruption, a certificate of need must be obtained before the former owner submits their notice of termination (see chapter 70.38 RCW for certificate of need requirements).

(2) If the new provider plans to participate in the cost related reimbursement system, they must meet the conditions specified in WAC 388-835-0215 and submit the projected budget required in WAC 388-835-0220. The new owner's CF/MR contract is effective on the date ownership changes.

(3) When a contract is terminated, the provider must reverse any accumulated liabilities assumed by a new owner against the appropriate accounts.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0205, filed 4/20/01, effective 5/21/01.]

PROSPECTIVE COST RELATED REIMBURSEMENT SYSTEM

WAC 388-835-0210 What is the prospective cost related reimbursement system (PCRRS)? PCRRS is the system used by DSHS pay for ICF/MR services provided to ICF/MR residents. Reimbursement rates for such services are determined according to the principles, methods, and standards contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0210, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0215 What are the requirements for participating in PCRRS? To participate in PCRRS, an entity responsible for operating an ICF/MR facility must:

(1) Obtain a state certificate of need as required by chapter 70.38 RCW, Health planning and development;

(2) Possess a current license to operate an appropriate facility (e.g., nursing home, boarding home);

(3) Be currently certified under Title XIX to provide ICF/MR services;

(4) Hold a current contract to provide ICF/MR services and comply with all of its provisions; and

(5) Comply with all applicable federal and state regulations, including the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0215, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0220 What are the projected budget requirements for new providers? (1) Unless the DDD director approves a shorter period, each new provider must submit a one-year projected budget to DSHS at least sixty days before the contract will become effective.

(2) The projected budget must cover the twelve months immediately following the date the provider will enter the program.

(3) The projected budget must:

(a) Be prepared according to DSHS instructions;

(b) Be completed on the forms provided by DSHS; and

(c) Include all earnest money, purchase, and lease agreements involved in the change of ownership transaction.

(4) A new provider must also clearly identify, in their projected budget, all individuals and organizations having a beneficial ownership interest in the:

(a) Current operating entity;

(b) Land, building, or equipment used by the facility; and

(c) Purchasing or leasing entity.

(5) For purposes of this section, a "new provider" is one:

(a) Operating a new facility;

(b) Acquiring or assuming responsibility for operating an existing facility; or

(c) Obtaining a certificate of need approval due to an addition to or renovation of a facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0220, filed 4/20/01, effective 5/21/01.]

FILING COST REPORTS

WAC 388-835-0225 How should cost reports be prepared? (1) All cost reports must be legible and reproducible. All entries must be in black or dark blue ink or submitted in an acceptable, indelible copy.

(2) All providers must complete reports according to the instructions provided by DSHS. If no specific instruction covers a particular situation, generally accepted accounting principles must be followed.

(3) All providers must use the accrual method of accounting, except for governmental institutions operated on a modified accrual basis.

(4) All revenue and expense accruals not received or paid within one hundred twenty days after the accrual is made must be reversed against the appropriate accounts, unless special circumstances are documented that justify continuing to carry all or part of the accrual (e.g., contested billings). Accruals for vacation pay, holiday pay, sick pay and taxes may be carried for longer periods if it is the provider's usual policy to do so and generally accepted accounting principles are followed.

(5) Methods of allocating costs, including indirect and overhead costs, must be consistently applied. Providers operating multiservice facilities or facilities incurring joint facility costs must allocate those costs according to the benefits received from the resources represented by those costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0225, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0230 Must a cost report be certified? (1) Every provider cost report required by DSHS must be accompanied by a certification signed on behalf of the provider who was responsible to DSHS during the reporting period.

(2) If a provider files a federal income tax return, the person normally signing the return and the ICF/MR facility administrator must sign the certification.

(3) If someone, who is not an employee of the provider, prepares the cost report, they must submit, as part of the certification, a signed statement indicating their relationship to the provider.

(4) Only original signatures must be affixed to certifications submitted to DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0230, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0235 When are cost reports due to DSHS? (1) Each private provider must submit an annual cost report to DSHS for the period January 1 through December 31 (calendar year) of the preceding year.

(2) Annual calendar year cost reports for a private facility must be submitted to DSHS by March 31 of the following year.

(3) Each state facility must submit an annual cost report to DSHS for the period from July 1 of the preceding year through June 30 of the current year (state fiscal year).

(4) Annual fiscal year cost reports for state facilities must be submitted to DSHS by December 31 following the end of the fiscal year.

(5) If a contract is terminated, the provider must submit a final cost report and any other reports due under subsection (2) within one hundred twenty days after the effective date of termination or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). For these reports, the reporting period is January 1 of the year of termination to the effective date of termination.

(6) A new provider must submit a cost report to DSHS by March 31 of the year following the effective date of their contract or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). The period to be reported is the period extending from the contract's effective date through December 31 of that year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0235, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0240 Does DSHS grant extensions for cost reporting deadlines? (1) DSHS, after receiving a written request stating why an extension is necessary, may grant a maximum of two thirty-day extensions for filing any required reports. However, the written request must be received at least ten days before the due date of the reports.

(2) DSHS grants extensions only when it is clear why the due date cannot be met and the circumstances requiring the extension were not foreseeable by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0240, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0245 What if a provider fails to submit a final report? (1) If a provider does not submit a final report, all payments received by the provider for the unreported period become a debt owed to DSHS. After receiving DSHS's written demand for repayment, the provider has thirty days to repay this debt.

(2) Interest, at the rate of one percent per month on any unpaid balance, will begin to accrue thirty days after the provider receives DSHS's written demand for repayment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0245, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0250 What if a provider submits improperly completed or late reports? (1) All providers must submit an annual report, including their proposed settlement by cost center, that is prepared according to this chapter's requirements and DSHS instructions. If an annual cost

report is not properly prepared, DSHS may return it, in whole or in part, to the provider for correction and/or completion.

(2) If DSHS does not receive a properly completed report, including any approved extensions, on or before its due date, all or part of any payments due under the contract may be withheld until the report is properly completed and received by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0250, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0255 What if a provider files a report containing false information? (1) Knowingly filing a report with false information (or with reason to know) is cause for termination of a provider's contract with DSHS.

(2) Any required adjustments to reimbursement rates because a false report was filed will be made according to WAC 388-835-0900.

(3) DSHS may refer for prosecution under applicable statues, any provider who files a false report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0255, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0260 Can providers amend annual cost reports filed with DSHS? DSHS must consider amendments to annual reports only when:

(1) Determining allowable costs affecting a final settlement computation, and

(2) Filed before the provider receives notification that a DSHS field audit has been scheduled.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0260, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0265 Can providers file amendments if a DSHS field audit has been scheduled? (1) A provider may file amendments after receiving a notice of a field audit only when reimbursement rates need to be adjusted because significant errors or omissions were made when they were calculated.

(2) Errors of omissions are considered "significant" if they result in a net difference of two cents or more per resident day or one thousand dollars or more in reported costs, whichever is higher, in any cost area.

(3) Only the pages requiring changes and the certification required by WAC 388-835-0335 must be filed with the amendment.

(4) Any adjustments to reimbursement rates resulting from an amended report will be made according to WAC 388-835-0885.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0265, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0265, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0270 Can providers file amendments if DSHS does not conduct a field audit? If DSHS does not conduct a field audit and the preliminary settlement report becomes the final report, DSHS must consider amendments only when filed within thirty days after the provider receives the final settlement report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0270, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0275 What requirements apply when amendments are filed? (1) When amendments are filed, a provider must report:

(a) The circumstances surrounding the amendments;

(b) The reasons why the amendments are needed; and

(c) All relevant supporting documentation.

(2) DSHS may refuse to consider any amendment that gives a provider a more favorable settlement or rate if the amendment is the result of:

(a) Circumstances over which the provider has control; or

(b) Good-faith error using the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by DSHS of an amendment to a cost report does not a release a provider from civil or criminal liability.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0275, filed 4/20/01, effective 5/21/01.]

MAINTAINING COST REPORT RECORDS

WAC 388-835-0280 Do ICF/MR providers have to maintain records related to their contracts? (1) A provider must, according to the terms of their contract, maintain adequate records so DSHS can audit reported data to verify provider compliance with generally accepted accounting principles and DSHS reimbursement principles and reporting instructions.

(2) If a provider maintains records based upon a chart of accounts other than the one established by DSHS, they must give DSHS a written schedule clearly illustrating how their individual account numbers correspond to those used by DSHS.

(3) After filing a report with DSHS, a provider must keep for five years, at a location in Washington state specified by the provider, all records supporting the report.

(4) If at the end of five years there are unresolved audit issues related to the report, the records supporting the report must be kept until the issues are resolved.

(5) Providers, according to the terms of their contract, must make records available for review upon demand by authorized personnel from DSHS and the United States Department of Health and Human Services during normal business hours at a location in Washington state specified by the provider.

(6) When a contract is terminated, final settlement must not be made until accessibility to and preservation of the provider's records within Washington state is assured.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0280, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0285 What if a provider fails to maintain records or refuses to let them be reviewed? (1) If a provider fails to maintain adequate records or fails to allow their inspection by authorized personnel, DSHS may suspend all or part of subsequent reimbursement payments due under the contract.

(2) Once the provider complies with the recording keeping and inspection provisions of their contract, DSHS must

resume current contract payments and must release payments suspended while the provider was out of compliance.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0285, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0290 Does DSHS have a responsibility to retain provider reports? (1) DSHS must retain required reports for five years following their filing date.

(2) If at the end of five years there are unresolved audit issues surrounding a report, the report must be retained until those issues are resolved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0290, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0295 Are the reports submitted to DSHS by providers available to the public? According to chapter 388-01 WAC, all required financial and statistical reports submitted by ICF/MR facilities to DSHS are public documents and available to the public upon request.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0295, filed 4/20/01, effective 5/21/01.]

FIELD AUDITS

WAC 388-835-0300 What is an ICF/MR field audit? A field audit consists of an on-site audit of the provider's financial records to verify that information provided on the cost report for the period being audited is accurate and represents allowable cost.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0300, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0305 When does DSHS schedule a field audit? (1) DSHS may schedule cost report field audits using auditors employed by or under contract with DSHS. DSHS must notify a facility selected for an audit within one hundred twenty days after the facility submits a completed and correct cost report.

(2) DSHS must give priority to field audits of final annual reports and, whenever possible, must begin these audits within ninety days after a properly completed final annual report is received.

(3) DSHS normally notifies a provider at least ten working days before the field audit begins.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0305, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0310 When does DSHS complete a field audit? (1) If auditors are given timely access to a ICF/MR facility and to all records necessary to conducting their audit, DSHS must complete an audit within one year:

(a) Of receiving a properly completed annual cost report; or

(b) After the facility is notified it has been selected for an audit.

(2) For a state ICF/MR, DSHS must complete a field audit within three years after a properly completed cost report is received if auditors are given timely access to the facility and all records necessary to conducting their audit.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0310, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0315 How should a provider prepare for a field audit? (1) A provider must allow auditors access to the ICF/MR facility and all financial and statistical records. These records must be available at a location in the state of Washington specified by the provider. They must include:

(a) All income tax returns relating to the audited cost report and work papers supporting the report's data; or

(b) Work papers related to resident trust funds.

(2) The provider must reconcile reported cost data with:

(a) Applicable federal income and payroll tax returns; and

(b) The financial statements for the period covered by the report.

(c) The reconciliation must be in a form that facilitates verification by the auditors.

(3) The provider must designate and make available to the auditors at least one individual familiar with the internal operations of the facility being audited. The designated individual(s) must have sufficient knowledge and access to records to effectively respond to auditor questions and requests for information and documentation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0315, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0320 What is the scope of a field audit? (1) Auditors must review a provider's record keeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) Auditors must examine a provider's financial and statistical records to verify that:

(a) Supporting records are in agreement with reported data; and

(b) Only assets, liabilities, and revenue and expense items that DSHS has specified as allowable costs have been included by the provider when computing the cost of services provided under the contract;

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care;

(d) Related organizations and beneficial ownership interests have been correctly disclosed; and

(e) Resident trust funds have been properly maintained.

(3) Auditors must give the provider a draft of their audit narrative and summaries for review and comment before the final narratives and summaries are prepared.

(4) When an audit discloses material discrepancies, undocumented costs, or mishandling of patient trust funds, DSHS auditors, in order to determine if similar problem exist and take corrective action, may:

(a) Reopen a maximum of two prior unaudited cost reporting or trust fund periods; and/or

(b) Select future periods for audit.

(c) DSHS auditors may select reported costs and trust fund accounts for audit on a random or other basis.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0320, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0325 What if an auditor discovers that provider reports are inadequately documented? (1) An auditor must disallow any assets, liabilities, revenues, or expenses reported as allowable that are not supported by adequate documentation in the provider's financial records.

(2) Adequate documentation must show that reported costs were:

(a) Incurred during the period covered by the report;

(b) Related to resident care and training; and

(c) Necessary, ordinary and prudent.

(3) Adequate documentation must also show that reported assets were used to provide resident care and training.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0325, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0330 Are final audit narratives and summaries available to the public? The auditor's final audit narrative and summaries are considered public documents and will be available to the public through the public disclosure process in chapter 388-01 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0330, filed 4/20/01, effective 5/21/01.]

RESIDENT TRUST ACCOUNTS

WAC 388-835-0335 What general requirements apply to accounting for resident trust accounts? (1) A provider must establish and maintain a bookkeeping system for all resident money received by the facility on behalf of the resident.

(2) This system must be incorporated into the facility's business records and be capable of being audited.

(3) The bookkeeping system must apply to residents that are:

(a) Incapable of handling their money and whose guardian, relative, DDD regional service office administrator, or physician requests in writing that the facility accept this responsibility. (If the Social Security Form SSA-780, "Certificate of Applicant for Benefits on Behalf of Another," is used as documentation, it must be signed by one of the persons designated in this subsection.)

(b) Capable of handling their own money, but they ask the facility, in writing, to accept this responsibility for them.

(4) It is the facility's responsibility to maintain written authorization requests in a resident's file.

(5) A resident must be given at least a quarterly reporting of all financial transactions affecting their account. The resident's representative payee, guardian and/or other designated agents must be sent a copy of this quarterly report or any other reports related to the resident's account.

(6) Facilities must purchase surety bonds, or otherwise provide assurances or security satisfactory to DSHS, that assures the security of all resident personal funds deposited with them.

(7) Facilities may not require residents to deposit personal funds with them. A facility may hold a resident's personal funds only if the resident or resident's guardian gives written authorization to do so.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0335, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0340 What specific accounting procedures apply to resident trust accounts? (1) A provider must maintain a subsidiary ledger with an account for each resident for whom the provider holds money in trust.

(2) Each account and related supporting information must be:

(a) Maintained at the facility;

(b) Kept current;

(c) Balanced each month; and

(d) Detailed, with supporting verification, showing all money received on behalf of the individual resident and how that money was used.

(3) A provider must make each resident trust account available to DSHS representatives for inspection and audit.

(4) A provider must maintain each resident trust accounts for a minimum of five years.

(5) A provider must notify the DDD regional service office when an individual's account balance is within one hundred dollars of the amount listed on their award letter.

(6) A resident can accumulate funds by:

(a) Not spending their entire clothing and personal incidentals allowance; and

(b) Saving other income DSHS specifically designates as exempt.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0340, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0345 Can residents overdraw their trust account? (1) A resident may not overdraw their account (show a debit balance).

(2) If residents want to spend an amount greater than the balance in their trust account, the facility may loan the residents money from facility funds.

(3) The facility can collect loans to residents by installments from the portion of the resident's allowance remaining at the end of each month.

(4) The facility cannot charge residents interest on these loans.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0345, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0350 Can a resident trust account be charged for Title XIX services? Resident trust accounts cannot be charged for services provided under Title XIX.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0350, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0355 Can a resident trust account be charged for medical services, drugs, therapy and equipment? (1) Any properly made charge to a resident's trust account for medical services must be supported by a written denial from DSHS.

(2) Any request for additional equipment such as a walker, wheelchair or crutches must have a written denial from DSHS before a resident's trust account can be charged.

(3) A request for physical therapy, certain drugs or other medical services must have a written denial from DSHS before a resident's trust account can be charged.

(4) A written denial from DSHS is not required when the pharmacist verifies a drug is not covered by the program (e.g., items on the FDA list of ineffective or possible effec-

tive drugs, nonformulary over-the-counter (OTC) medications such as vitamins, nose drops, etc.) The pharmacist's notation that the program does not cover the drugs is sufficient.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0355, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0360 Can providers create petty cash funds for residents? (1) Providers may maintain petty cash funds for residents.

(2) The fund must be an imprest type fund.

(3) The cash for the fund must come from trust money.

(4) The amount of the fund must be reasonable and necessary for the size of the facility and the needs of the residents, but must not exceed five hundred dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0360, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0365 Can providers create checking accounts for residents? (1) A provider must deposit all money, over and above the trust fund petty cash amount, intact into a trust fund checking account that is separate and apart from any other bank account(s) of the facility or other facilities.

(2) Deposits of resident allowances must be made intact into the trust checking account within one week from the time payment is received from DSHS, Social Security Administration, or any other payor.

(3) A provider must make any related bankbooks, bank statements, check book, check register, all voided and all canceled checks available to DSHS representatives for audit and inspection. The provider must retain these supporting records and documents for at least five years.

(4) Resident trust money cannot be used to pay checking account service charges.

(5) Each banks trust account must be reconciled each month to the trust account ledger for each resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0365, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0370 What controls must a provider use to ensure the safety of trust fund money? (1) A provider must not release trust fund money to anyone other than the:

(a) Resident or, with their written consent, their guardian;

(b) Resident's designated agent as appointed by power of attorney; or

(c) Appropriate DSHS personnel designated by the DDD regional services administrator.

(2) A provider must complete a receipt, in duplicate, when money is received. One copy must be given to the person making the payment or deposit and the other copy must remain in the receipt book for easy reference.

(3) All residents must endorse, with their own signature, any checks or state warrants they receive. Only when a resident is incapable of signing their own name may the provider use the resident's "X" mark followed by their printed name and the signature of two witnesses.

(4) When both a general fund account and a trust fund account are kept at the same bank, the trust account portion of any deposit can be deposited directly to the trust account.

(5) A provider must credit a resident's trust account ledger sheet when the resident's allowance is received. This entry must be referenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0370, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0375 Can a resident withdraw trust money? Any money held in trust for a resident must be available to them for their personal and incidental needs upon their request or the request of one of the individuals designated in WAC 388-835-0335.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0375, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0380 What happens to resident funds when a change of ownership occurs? (1) When a facility is sold or some other transfer of ownership takes place, the former provider must provide the new provider with a written accounting, based upon generally accepted auditing standards, of all resident funds being transferred. The former provider must also obtain a written receipt for the funds from the new provider.

(2) Before any transfer of ownership occurs, the facility must give each resident, or their representative, a written accounting of any personal funds held by the facility.

(3) If there is disagreement regarding the accounting offered by the former provider, the resident retains all rights and remedies provided under state law.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0380, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0385 How are trust fund moneys refunded? When a resident is discharged and/or transferred, the balance of their trust account, along with a receipt, will be returned to the individual designated in WAC 388-835-0335 within thirty days of the resident's transfer or discharge.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0385, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0390 How are trust funds liquidated? (1) In the case of deceased resident, the provider must obtain a receipt from the next-of-kin, guardian, or duly qualified agent when the balance of the trust fund is released. If the next-of-kin, guardian or duly qualified agent cannot be identified, the DDD regional service office must be contacted, in writing within seven days of the resident's death, to assist in the release of the resident's trust fund money. A check or other document showing payment to the next-of-kin, guardian, or duly qualified agent will serve as a receipt.

(2) In situations where the resident leaves the ICF/MR facility without authorization and their whereabouts is unknown, the facility:

(a) Will make a reasonable attempt to locate the missing resident. A "reasonable attempt" includes, but is not limited

to, contacting friends, relatives, police, the guardian, and the DDD regional office in the area; and

(b) If the resident cannot be located after ninety days, the facility must notify the department of revenue regarding the existence of "abandoned property" (see chapter 63.29 RCW Uniform Unclaimed Property Act). The facility must deliver to the department of revenue the balance of the resident's trust fund account within twenty days following their notification.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0390, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0395 How must a facility maintain resident property records? (1) A facility must maintain a current, written record for each resident that includes written receipts for all personal property entrusted to the facility by the resident.

(2) All property records must be available to the resident or designated resident representative (see WAC 388-835-0380).

(3) A facility must issue or obtain written receipts when taking possession or disposing of a resident's personal property. The facility must retain copies and/or originals of these receipts.

(4) A facility must maintain all resident property records so they are available to auditors and in a manner that facilitates the audit process.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0395, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0395, filed 4/20/01, effective 5/21/01.]

ALLOWABLE AND UNALLOWABLE COSTS

WAC 388-835-0400 What are allowable costs? (1) Allowable costs are documented costs that are necessary, ordinary, related to providing ICF/MR services to ICF/MR residents, and not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude that a prudent and cost conscious management would pay.

(2) Allowable costs do not include increased costs resulting from transactions or the application of accounting methods which circumvent the principles of the prospective cost-related reimbursement system.

(3) DSHS does not allow increased costs resulting from a series of transactions between the same parties and involving the same assets (e.g., sale and leaseback, successive sales or leases of a single facility or piece of equipment).

(4) When a provider requests a rate adjustment according to WAC 388-835-0900 or 388-835-0905, any cost audited previously and not disallowed is subject to DSHS review and reconsideration according to the criteria in this section.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0400, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0405 What are unallowable costs? (1) Costs are unallowable if they are not documented, necessary, or ordinary and do not relate to providing services to ICF/MR residents.

(2) Examples of unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the medicaid program. Costs of nonprogram items or services will not be allowed even if indirectly reimbursed by DSHS as a result of an authorized reduction in resident contribution.

(b) Costs of services and items provided to ICF/MR residents covered by DSHS's medical care program but not included in ICF/MR services.

(c) Costs associated with a capital expenditure subject to Section 1122 approval (part 100, Title 42 CFR) if DSHS found the expenditure was not consistent with applicable standards, criteria, or plans. If DSHS was not given timely notice of a proposed capital expenditure, all associated costs will not be allowed as of the date the costs were determined to be nonreimbursable under applicable federal regulations.

(d) Costs associated with a construction or acquisition project that requires certificate of need approval according to chapter 70.38 RCW and that approval was not obtained.

(e) Costs associated with outside activities (e.g., costs allocable to the use of a vehicle for personal purposes, or related to the part of a facility leased out for office space).

(f) All salaries or other compensation of officers, directors, stockholders, and others associated with the provider or home office, except compensation paid for services related to resident care and training.

(g) Costs in excess of limits set in this chapter or costs violating principles contained in this chapter.

(h) Costs resulting from transactions or the application of accounting methods used to circumvent the principles of the prospective cost-related reimbursement system.

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of cost to the related organization or market meaning the price paid for comparable services, facilities or supplies when purchased in an arms length transaction.

(j) Balances of accounts that cannot be collected (bad debts or uncollectable accounts).

(k) Charity and courtesy allowances.

(l) Cash, assessments, or other contributions to political parties, and cost incurred to improve community or public relations. Dues to charitable organizations, professional organizations and trade associations are allowable costs.

(m) Any portion of trade association dues for legal and consultant fees and costs related to lawsuits or other legal action against DSHS.

(n) Travel expenses for trade association boards of directors in excess of the twelve allowable meetings per calendar year.

(o) Vending machine expenses.

(p) Expenses for barber or beautician services not included in routine care.

(q) Funeral and burial expenses.

(r) Costs of gift shop operations and inventory.

(s) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in resident activity programs or in ICF/MR programs where clothing is a part of routine care.

(t) Fund-raising expenses except those directly related to the resident activity program.

(u) Penalties and fines.

(v) Expenses related to telephones, televisions, radios, and similar appliances in a resident's private accommodations.

(w) Federal, state, and other income taxes.

(x) Costs of special care services, except where authorized by DSHS.

(y) Expenses for "key-person" insurance and other insurance or retirement plans not available to all employees.

(z) Expenses of profit-sharing plans.

(aa) Expenses related to the purchase and/or use of private or commercial aircraft that exceed what a prudent provider would spend for ordinary and economical transportation when conducting resident care business.

(bb) Personal expenses and allowances of owners or relatives.

(cc) All expenses of maintaining professional licenses or membership in professional organizations.

(dd) Costs related to agreements not to compete.

(ee) Goodwill and the amortization of goodwill.

(ff) Expenses related to vehicles in excess of what a prudent provider would expend for the ordinary and economic provision of transportation needs related to resident care.

(gg) Legal and consultant fees related to a fair hearing against DSHS. Including but not limited to, fees for accounting services used to prepare for an administrative judicial review resulting in a final administrative decision favorable to DSHS or where DSHS's decision is allowed to stand.

(hh) Legal and consultant fees related to a lawsuit against DSHS, including suits appealing administrative decisions.

(ii) Lease acquisition costs and other intangibles not related to resident care and training.

(jj) Interest charges assessed by the state of Washington for failure to make timely refund of overpayments and interest expenses incurred for loans obtained to make such refunds.

(kk) Travel expenses outside the states of Idaho, Oregon, and Washington and the Province of British Columbia except travel to and from the home and central office of a chain organization operation outside those areas if the travel is necessary, ordinary, and related to resident care and training.

(ll) Moving expenses of employees when a demonstrated, good-faith effort has not been made to recruit employees within the states of Idaho, Oregon, and Washington and Province of British Columbia.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0405, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0410 Can a provider offset miscellaneous revenues against allowable costs? (1) A provider must reduce allowable costs whenever the item, service, or activity covered by the costs generate revenue or financial benefits (e.g., purchase discounts or rebates) other than through the provider's normal billing for ICF/MR services.

(2) A provider must not deduct unrestricted grants, gifts, endowments, and interest earned from them from the allowable costs of a nonprofit facility.

(3) When goods or services are sold, the reduction in allowable costs must be the actual cost of the item, service, or activity. If actual cost cannot be accurately determined, the reduction must be the full amount of the revenue received. When financial benefits such as purchase discounts or rebates are received, the reduction must be the amount of the discount or rebate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0410, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0415 Are the costs of meeting required standards allowable costs? (1) All necessary and ordinary expenses incurred by a provider to meet required standards associated with providing ICF/MR services are allowable costs.

(2) Examples are the cost of:

(a) Meeting licensing and certification standards;

(b) Fulfilling accounting and reporting requirements imposed by this chapter; and

(c) Performing any resident assessment activity required by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0415, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0420 Are costs associated with related organizations allowable costs? (1) DSHS allows costs applicable to services, facilities, and supplies furnished to a provider by a related organization only to the following extent:

(a) The costs do not exceed the lower of the cost to the related organization; or

(b) Market, meaning the price paid for comparable services, facilities, or supplies when purchased in an arm's length transaction.

(2) Private facilities must make all cost documentation regarding related organizations available to the auditors at the time and place the entity's financial records are audited. State facilities must make all cost documentation regarding related organizations available to the auditors at DSHS's offices of accounting services, financial recovery, or budget when the facility is audited.

(3) DSHS disallows all payments to or for the benefit of a related organization where the cost to the related organization cannot be documented.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0420, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0425 Are start-up costs allowable costs? DSHS allows all necessary and ordinary start-up costs in the administration and operations rate component. Start-up costs must be amortized over at least sixty consecutive months beginning with the month the first resident is admitted for care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0425, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0430 Are organizational costs allowable costs? (1) DSHS allows necessary and ordinary costs directly related to the creation of a provider's corporation or other form of business that are incurred before the admission of the first resident.

(2) DSHS allows these costs in the administration and operation cost area if they are amortized over at least sixty

consecutive months beginning with the month in which the first resident is admitted for care.

(3) Examples of allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation.

(4) Organization costs do not include costs relating to the issuance and sale of shares of stock or other securities.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0430, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0435 Are education and training costs allowable costs? (1) DSHS allows ordinary expenses associated with on-the-job and in-service training required for employee orientation and certification when those expenses directly relate to performing an employee's assigned duties.

(2) Ordinary expenses for staff training are allowable costs.

(3) Necessary and ordinary expenses for recreational and social activity training conducted by a provider for volunteers are allowable costs.

(4) Training program expenses for other nonemployees are not allowable costs, except the costs associated with training county-contracted training program employees by an ICF/MR as a condition of the ICF/MR's agreement with the county-contracted training program.

(5) DSHS must allow expenses for travel in the states of Idaho, Oregon, and Washington and Province of British Columbia associated with education and training if the expenses meet the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0435, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0440 Are operating lease costs allowable costs? Facility and/or equipment rental or lease costs associated with an arm's length operating lease are allowable costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0440, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0445 Are rental expenses paid to related organizations allowable costs? The expense of renting facilities or equipment from a related organization are allowable to the extent that the rent paid does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets. Computing the related organization's cost of owning or leasing the asset must be according to the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0445, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0450 What is allowable interest? (1) DSHS allows a provider's necessary and ordinary interest costs incurred for working capital loans and capital indebtedness.

(a) "Necessary" means the interest expense must be incurred in connection with a loan satisfying a financial need of the provider and for a purpose related to resident care and training. Interest expense related to a business opportunity or goodwill is unallowable.

(b) "Ordinary" means the interest rate for the loan must not exceed the rate a prudent borrower would pay, in an arm's length transaction, for a comparable loan in the money market at that time.

(c) Interest expense must include amortization of bond discounts and expenses related to the bond issue. The amortization period must be the period from the date the bonds are sold to their maturity date or their date of extinguishment if they are retired before they mature.

(d) Interest expense for assets acquired in a change of ownership after September 30, 1984, is disallowed on any loan principal in excess of the former owner's depreciation base on July 18, 1984.

(2) Interest that is paid to or for the benefit of a related organization is allowed but only to the extent that the actual interest does not exceed the related organization's cost of using the funds.

(3) For construction loans, a provider must capitalize interest expense and loan origination fees incurred during the period of construction. Such costs must be amortized over the life of the constructed asset beginning with the date the first resident is admitted or the date the asset is put into service, whichever occurs first.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0450, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0455 Can a provider offset interest income against allowable costs? Except for nonprofit facilities, a provider must deduct from allowable interest expense all interest income earned from either investing or lending nonrestricted and restricted funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0455, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0460 How does DSHS calculate total compensation for owners and relatives? (1) Total compensation means the compensation provided in the employment contract, including benefits. The employment contract can be written, verbal, or inferred from the acts of the parties.

(2) In the absence of a contract, total compensation includes gross salary or wages and fringe benefits (e.g., health insurance) available to all employees.

(3) Total compensation does not include payroll taxes paid by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0460, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0465 How does DSHS define owner or relative compensation? (1) DSHS limits the total compensation of an owner or an owner's relative to the ordinary compensation for necessary services actually performed.

(a) Compensation is ordinary if it is the amount usually paid for comparable services in a comparable facility to an unrelated employee, and does not exceed limits established in this chapter.

(b) A service is necessary if it is related to resident care and training and would have to be performed by another person if the owner or relative did not perform it.

(2) A provider, in maintaining customary time records adequate for audit, must include time records for owners and

relatives receiving compensation. These records must document how compensated time was spent performing necessary services.

(3) For purposes of this section, if the provider is a corporation, "owner" includes all corporate officers and directors.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0465, filed 4/20/01, effective 5/21/01.]

CAPITALIZED COSTS AND DEPRECIATION

WAC 388-835-0470 What requirements apply to capitalizing equipment, including furniture and furnishings? A provider must capitalize equipment, including furniture and furnishings according to the following table:

Equipment, including furniture and furnishings	Historical cost	Useful life
For settlement purposes beginning January 1, 1881 and for rate setting purposes beginning July 1, 1982	At least $500 per item	At least one year from date asset is put into service
For settlement purposes beginning January 1, 1990 and for rate setting purposes beginning July 1, 1990	At least $1,000 per item	At least one year from date asset is put into service
For settlement purposes beginning January 1, 1996 and for rate setting purposes beginning July 1, 1996	At least $500 per item	At least one year

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0470, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0475 What requirements apply to capitalizing buildings, other real property items, components, improvements and leasehold improvements? Buildings and other real property items, components, improvements and leasehold improvements must be capitalized if they are:

(1) Required or authorized by the lease agreement;

(2) Cost more than five hundred dollars; and

(3) Involve at least one of the following:

(a) Increase the interior floor space of the structure;

(b) Increase or renew paved areas outside the structure that are either adjacent to the structure or provide access to it;

(c) Modification to the exterior or interior walls of the structure;

(d) Installation of additional heating, cooling, electrical, water-related, or similar fixed equipment;

(e) Landscaping or redecorating; or

(f) Increasing the structure's useful life by at least two years.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0475, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0480 How are the useful lives of leasehold improvements determined? The useful lives for all leasehold improvements are based upon the American Hospital Association (AHA) guidelines for the applicable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0480, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0485 What are depreciable assets? Depreciable assets are tangible assets that are subject to depreciation and in which a provider has an ownership interest.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0485, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0490 What are some examples of depreciable assets? Some examples of depreciable assets are:

(1) Buildings, meaning the basic structure or shell and additions to it.

(2) Equipment such as elevators, heating system, and air conditioning system that are attached to a building and characterized by:

(a) An economic useful life of at least three years but shorter than the life of the building to which it is attached;

(b) Incapable of being removed from the building to which it is attached;

(c) A unit cost sufficiently large enough to justify ledger control; and

(d) A physical size and identity that makes control by identification tags possible.

(3) Equipment not attached to buildings.

(4) Land improvements such as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, wall, etc., where replacement is the responsibility of the provider.

(5) Leasehold improvements and additions made by the lessee belong to the lessor after the lease expires.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0490, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0495 What is "minor equipment"? (1) Minor equipment includes items such as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets.

(2) Minor equipment is generally characterized as:

(a) Not occupying a fixed location and is used by a variety of departments;

(b) Small in size and unit cost;

(c) Subject to inventory control;

(d) A fairly large number of items are in use; and

(e) Possessing a useful life of one to three years.

(3) If properly capitalized (see WAC 388-835-0230), minor equipment is depreciated. If not properly capitalized, minor equipment is expensed when acquired.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0495, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0500 Is land a depreciable asset? Because the economic useful life of land is considered to be unlimited, land is not a depreciable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0500, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0505 What costs are included in the capitalized cost of land? Examples of costs that are capitalized as land costs include the cost of:

(1) Off-site sewer and water lines;

(2) Public utility charges necessary to service the land;

(3) Government assessments for street paving and sewers;

(4) Permanent roadways and grading of a nondepreciable nature; and

(5) Curbs and sidewalks, the replacement of which is not the responsibility of the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0505, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0510 What is the depreciation base of a tangible asset? (1) The depreciation base of a tangible asset is the asset's historical cost at the time it is acquired by the provider in an arm's length transaction:

(a) Plus the cost of preparing the asset for use;

(b) Less the asset's estimated salvage value, if any, where the straight-line or sum-of-the-years digits methods of depreciation is used;

(c) Less any goodwill; and

(d) Less any accumulated depreciation incurred during periods the asset was used by the provider personally or in another business.

(2) When depreciable assets are acquired from a related organization, the provider's depreciation base cannot exceed the base the related organization had or would have had under a contract with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0510, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0515 Can an appraisal be used to establish historical cost? (1) If DSHS challenges the historical cost of an asset or if a provider is unable to adequately document the historical cost of an asset, the department may use an appraisal process to establish the asset's fair market value at the time of purchase.

(2) If an appraisal process is used to establish the fair market value of equipment, vendors dealing in that particular type of equipment must perform the appraisals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0515, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0520 What is the depreciation base of a donated or inherited asset? (1) The depreciation base of donated and/or inherited assets is the lesser of:

(a) Fair market value at the date of donation or death, less goodwill. (Any estimated salvage value must be deducted from fair market value when either the straight-line or sum-of-the-years digits method of depreciation is used); or

(b) The historical cost of the last owner to contract with DSHS, if any.

(2) If the donation or distribution is between related organization, the base must be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value, or

(b) The depreciation base the related organization used or would have used when contracting with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0520, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0525 How is the useful life of a depreciable asset determined? (1) Except for buildings, a provider must not adopt useful lives shorter than the guideline lives contained in the Internal Revenue Service class life ADR system or published by the American Hospital Association. Thirty years is the shortest useful life a provider can adopt for buildings.

(2) Useful life is measured from the date of the most recent arm's length acquisition of the asset.

(3) Building improvements to owned or leased buildings must be depreciated over the remaining useful life of the building or fifteen years, whichever is greater, except for improvements to licensed boarding home facilities required by the Fire Safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A provider must receive DSHS approval before following this exception.

(4) Improvements to leased property that are, according to the lease agreement, the responsibility of the provider must be depreciated over the useful life of the improvement, except for improvements to licensed boarding home facilities required by the Fire safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A provider must receive DSHS approval before following this exception.

(5) A provider may change the estimated useful life of an asset to a longer period if necessary.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0525, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0530 What depreciation methods are approved by DSHS? (1) Buildings, building improvements, land improvements, leasehold improvements, and fixed equipment must be depreciated using the straight-line method.

(2) Equipment must be depreciated using the straight-line method, the sum-of-the-years digits method, or the declining balance method at a rate not to exceed one hundred fifty percent of the straight-line rate. Providers electing to use either the sum-of-the-years digits method or the declining balance method may change to the straight-line method without permission of the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0530, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0535 What is depreciation expense? (1) Depreciation expense on tangible assets used to provide ICF/MR services is an allowable cost.

(2) Depreciation expense must be:

(a) Identifiable and recorded in the provider's accounting records; and

(b) Computed using the depreciation base, useful lives and methods specified in this chapter.

(3) If a provider reports annual depreciation expense that includes depreciation on assets unrelated to resident care and

training, the annual reported expense must be reduced accordingly.

(4) Once a tangible asset is fully depreciated, no additional depreciation can be claimed unless a new depreciation base is established according to the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0535, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0540 Can providers claim depreciation on assets that are abandoned, retired or disposed of in some other way? (1) Depreciation cannot be claimed on tangible assets that are sold, traded, scrapped, exchanged, stolen, wrecked or destroyed by fire or some other casualty.

(2) Depreciation cannot be claimed on permanently abandoned assets.

(3) If an asset has been retired from active use but is being held for stand-by or emergency service and DSHS has determined that the asset is needed and can be effectively used in the future, depreciation may be claimed by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0540, filed 4/20/01, effective 5/21/01.]

GAINS AND LOSSES ON RETIRED ASSETS

WAC 388-835-0545 How must providers account for gains and losses on the retirement of tangible assets? For settlement purposes beginning with January 1, 1981 and for rate setting purposes beginning with the July 1, 1982 rate period, the rules in WAC 388-835-0265 through 388-835-0275 apply.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0545, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0550 How are gains and losses calculated when a tangible asset is retired? When a tangible asset is retired, the difference between the assets undepreciated base and any proceeds received from its retirement is considered a gain or loss on retirement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0550, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0555 How must providers account for gains and losses on retired assets that are replaced? If a provider replaces a retired asset, any gain or loss on retirement must be deducted from or added to the cost of the replacement asset, respectively. However, a loss on retirement can only be added to the replacement asset's cost if the provider makes a reasonable effort to recover at least the outstanding book value of the retired asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0555, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0560 How must providers account for gains and losses on retired assets that are not replaced? (1) If a retired asset is not replaced the gain or loss on retirement must be spread over the actual life of the asset up to the date of retirement. However, a loss can only be spread if the provider has made a reasonable effort to recover at least the outstanding book value of the retired asset.

(2) DSHS will calculate any difference between the actual reimbursements paid and the amount of reimbursement that should be paid after the gain or loss is spread. If the difference results from a gain DSHS must recover the difference from the provider. If the difference results from a loss the difference will be added to allowable costs when determining the settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0560, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0565 How must providers account for gains and losses on retired assets if they terminate their contract with DSHS? If a retired asset is not replaced and the provider is terminating their contract with DSHS, the gain or loss on retirement must be accounted for according to the requirements in WAC 388-835-0280.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0565, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0570 Can DSHS recover reimbursements for depreciation expense? If a provider terminates their contract without selling or otherwise retiring equipment that was depreciated using an accelerated method, depreciation schedules for this equipment for those periods when the provider participated in the ICF/MR program must be adjusted. DSHS will recover any difference between reimbursement actually paid for depreciation and the reimbursement that would have been paid if the straight-line method had been used.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0570, filed 4/20/01, effective 5/21/01.]

REIMBURSEMENT RATES

WAC 388-835-0575 What requirements apply to calculating ICF/MR reimbursement rates? (1) Medicaid program reimbursement rates established according to this chapter apply only to facilities holding appropriate state licenses and certified to provide ICF/MR services according to state and federal laws and regulations.

(2) All rates must be reasonable and adequate to meet the costs incurred by economically and efficiently operated facilities providing ICF/MR services according to state and federal laws and regulations.

(3) For private facilities:

(a) Final payments must be the lower of the facility's prospective rate or allowable costs.

(b) Prospective rates must be determined according to WAC 388-835-0845, 388-835-0850, 388-835-0860, 388-835-0865, 388-835-0870, 388-835-0875, and 388-835-0880.

(c) Final payments must be determined according to WAC 388-835-0880.

(4) For state facilities:

(a) Final payments must be the facility's allowable costs.

(b) Interim rates must be calculated using the most recent annual reported costs (see WAC 388-835-0845) divided by the total resident days during the reporting period. These costs may be adjusted to incorporate federal, state, or department changes in program standards or services.

(c) Final payments must be determined according to WAC 388-835-0880.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0575, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0575, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0580 What program services are not covered by DSHS prospective reimbursement rates? Medical services that are part of DSHS's medical care program but not included in ICF/MR services are not covered by prospective reimbursement rates. Payments are made directly to the service provider according to WAC 388-835-0835 requirements.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0580, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0585 What requirements apply to prospective reimbursement rates for new providers? (1) A prospective reimbursement rate for a new provider must be established within sixty days after DSHS receives a properly completed projected budget from the provider. The effective date of the reimbursement rate must be the same as the effective date of the contract.

(2) The prospective reimbursement rate must be based on the:

(a) Provider's projected cost of operation;

(b) Costs and payment rates of the prior provider, if any; and/or

(c) Costs and payment rates, taking into account applicable lids or maximums, of other providers in comparable circumstances.

(3) If DSHS does not receive a properly completed projected budget at least sixty days before the contract's effective date, a preliminary rate, based on information from former and/or comparable providers, will be prepared by DSHS. This preliminary rate must remain in effect until an initial prospective rate can be set.

(4) If a change of ownership takes place that does not result from an arm's length transaction, the new provider's prospective rates for administration, operations and property costs cannot exceed the former provider's rates. The former provider's rates can be adjusted, if necessary, to reflect changes in economic trends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0585, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0590 How are reimbursement rates calculated? (1) Each provider's reimbursement rate must be recalculated once each calendar year. The recalculated rate will be implemented prospectively. The recalculated rate will be effective on July 1 of the calendar year in which it was computed. Rates may be recalculated to reflect legislative inflation adjustments or to comply with the requirements of WAC 388-835-0900.

(2) If a provider participated in the ICF/MR program for at least six months during the previous calendar year, their rates must be based on the prior period's allowable costs. If the provider participated in the program for less than six months in the previous calendar year, their rates must be calculated according to WAC 388-835-0840 requirements.

(3) Unless circumstances beyond DSHS's control interfere, all providers submitting correct and complete cost reports by March 31 must receive notification of their new rates by July 1.

(4) When calculating a provider's rate, DSHS must use data from the most recent and complete cost report submitted by the provider and reviewed by DSHS as described in WAC 388-835-0700.

(5) Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0590, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0595 When does DSHS review a provider's annual cost report? DSHS must review and analyze each annual cost report within six months after it is properly completed and filed with the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0595, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0600 What is the purpose of reviewing a provider's annual cost report? DSHS reviews and analyzes annual cost reports to determine if the information contained in them is correct, complete, and reported according to generally accepted accounting principles, the requirements of this chapter and any other applicable rules and instructions issued by the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0600, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0605 What is the scope of an annual cost report review? (1) DSHS' review and analysis may include, but is not limited to:

(a) An examination of prior years reported costs;

(b) An examination of any cost report review adjustments made in prior years and their final disposition;

(c) An examination of findings, if any, from prior year cost report field audits; and

(d) Findings, if any, from the field audit of the cost report currently being reviewed.

(2) If it appears that a provider incorrectly calculated or reported their costs, DSHS may:

(a) Request additional information from the provider;

(b) Schedule a special field audit of the provider; or

(c) Make adjustments to the reported information. If adjustments are made, DSHS must give the provider a schedule of the adjustments including an explanation for each one and the dollar amount associated with each one.

(3) If the provider believes that DSHS adjustments are incorrect, the adjustments must be reviewed according to WAC 388-835-0900. If this review does not satisfactorily resolve the dispute, the adjustment must be further reviewed according to WAC 388-835-0910.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0605, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0610 Can DSHS accumulate cost report information and use if for department purposes? DSHS may accumulate data from properly completed cost reports for:

(1) Use in exception profiling and establishing rates; and

(2) Analytical, statistical, or informational purposes that the department considers important.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0610, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0615 What are component rates and cost centers? (1) A provider's overall ICF/MR resident reimbursement rate consists of five component rates within three cost centers.

(2) The five component rates are:

(a) Resident care and habilitative services;

(b) Food;

(c) Administration and operations;

(d) Property; and

(e) Return on equity.

(3) The three cost centers are:

(a) Resident care and habilitation;

(b) Administration, operations, and property; and

(c) Return on equity.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0615, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0620 What reimbursement requirements apply to resident care and habilitation cost centers? (1) Resident care and habilitation cost centers at facilities with at least sixteen residents and licensed as a nursing facility, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services.

(2) Resident care and habilitation cost centers at facilities with less than sixteen residents and licensed as a boarding home, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services. These cost centers must also reimburse for resident care and training staff who perform any of the administration and operations functions specified in WAC 388-835-0870.

(3) A facility's resident care and habilitation cost center rate must be its most recent reported costs per resident day adjusted for inflation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0620, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0625 What requirements apply to administration, operations and property cost center rates? Administration, operations, and property cost center rates are the sum of three separate rate components:

(1) The food rate component established by WAC 388-835-0865;

(2) The administration and operations rate component established by WAC 388-835-0870; and

(3) The property rate component established by WAC 388-835-0875.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0625, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0630 What is the food rate component? The food rate component reimburses for the necessary and ordinary costs of a resident's bulk and raw food, dietary supplements, beverages with meals and nourishment between meals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0630, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0635 Is there a limit to the allowable cost for administrative personnel? Compensation for administrative personnel is an allowable cost within the limits contained in this section:

(1) For purposes of this section "compensation" means gross salaries, wages, and the applicable cost of fringe benefits made available to all employees. Compensation does not include payroll taxes paid by the provider.

(2) A licensed administrator's total compensation for actual services rendered to an ICF/MR facility on a full-time basis (at least forty hours per week, including reasonable vacation, holiday, and sick time) is allowable at the lower of:

(a) Actual compensation received; or

(b) For calendar year 2000, the amount specified in the following table that corresponds to the number of set-up beds in the facility.

Number of set-up beds	Maximum compensation
15 or less	$42,886
16 to 79	$47,739
80 to 159	$52,832
160 and up	$56,163

(c) The maximum compensation amounts will be adjusted annually for inflation. Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

(d) A licensed administrator's compensation will be allowed only if DSHS is notified in writing within ten days following the start of their employment.

(3) Total compensation of not more than one full-time licensed assistant administrator will be allowed if there are at least eighty set-up beds in the ICF/MR facility. Compensation is allowable at the lower of:

(a) Actual compensation received; or

(b) Seventy-five percent of the amount specified in the above table.

(4) Total compensation of not more than one full-time registered administrator-in-training is allowed at the lower of:

(a) Actual compensation received; or

(b) Sixty percent of the amount specified by DDD in the above table.

(5) The cost of a licensed administrator, assistant administrator, or administrator-in-training is not an allowable expense in ICF/MR facilities with fifteen beds or less. The facility's qualified mental retardation professional (QMRP) will provide administrative services.

(6) A QMRP's total compensation of wages and/or salary is allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in DDD in the above table.

(7) If a licensed administrator, licensed assistant administrator, registered administrator-in-training, or QMRP are employed on a less than full-time basis, allowable compensation must be the lower of:

(a) Actual compensation received; or

(b) The maximum amount allowed multiplied by the percentage derived from dividing actual hours worked plus reasonable vacation, holiday and sick time, by two thousand and eighty hours.

(8) A provider must maintain time records for any licensed administrators, assistant administrators, administrators-in-training, or QMRPs they employ.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0635, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0640 Can a provider hire an individual or firm to manage their ICF/MR facility? (1) A provider can enter into an agreement with an individual or firm to manage their ICF/MR facility as the provider's agent, however, the provider must submit a copy of the agreement to DSHS at least sixty days before it becomes effective.

(2) Copies of any amendments to a management agreement must be received by DSHS at least thirty days before the amendment become effective.

(3) Management fees for periods before DSHS receives a copy of the agreement are not allowable costs.

(4) The department may waive the sixty-day notice requirement to protect the health and safety of facility residents. Any waiver of the sixty-day notice requirement by DSHS must be in writing.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0640, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0645 Are management fees allowable costs? Management fees are allowable costs only when there is:

(1) A written management agreement that:

(a) Creates a principal and/or agent relationship between the provider and the manager; and

(b) Identifies the items, services, and activities that the manager will provide.

(2) Documentation that verifies the management service was performed.

(3) Assurance that the service performed was necessary and did not duplicate any service provided by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0645, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0650 Are all management fee's allowable? Providers must limit the amount of allowable fees for general management services (including corporate management fees, business entity management fees, board of director fees and overhead and indirect costs associated with providing general management services) to:

(1) The maximum allowable compensation for a licensed administrator and, if the facility has at least eighty set-up beds, an assistant administrator even if one is not employed minus the actual compensation received by the licensed administrator and assistant administrator.

(2) The maximum allowable compensation for a QMRP at a ICF/MR facilities with fifteen beds or fewer, minus the actual compensation received by the QMRP.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0650, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0655 Are management fees involving a related organization allowable costs? (1) A management fee paid to or for the benefit of a related organization is allowable if it does not exceed the lesser of:

(a) The limits set out in WAC 388-835-0400; or

(b) The lower of the related organization's actual cost of providing necessary resident care and training services under the management agreement or the cost of comparable services purchased in an arm's length transaction elsewhere.

(2) If related organization costs are joint facility costs, their measurement must comply with the requirements of WAC 388-835-0400.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0655, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0660 How do overhead and indirect costs relate to allowable costs? (1) For general administrative and management services, costs such as central office costs, owner compensation, and other fees or compensation, including joint facility costs, must include the overhead and indirect costs associated with providing general management services that are not allocated to specific services.

(2) General administrative and management service costs as described in subsection (1) of this section are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0660, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0665 Are travel and housing expenses of nonresident staff working at a provider's ICF/MR facility allowable costs? (1) All necessary travel and housing expenses of nonresident staff working at a provider's ICF/MR facility are allowable costs if their visit does not exceed three weeks.

(2) If the nonresident staff visit extends beyond three weeks, any travel and housing expenses are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0665, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0670 Are bonuses paid to a provider's employees allowable costs? (1) Bonuses paid to employees at a provider's ICF/MR facility are compensation.

(2) Bonuses paid to central office employees are management costs that are subject to the management fee limits established in WAC 388-835-0405.

(3) Bonuses paid to other employees not located at an ICF/MR facility and performing managerial services are management costs that are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0670, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0675 Are fees paid to members of the board of directors or corporations allowable costs? Fees paid to board of director members or corporations operating ICF/MR facilities are management costs subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0675, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0680 How is the administration and operations rate component computed? (1) The administration and operations rate component includes reimbursement for the necessary and ordinary costs of:

(a) Overall administration and management of the facility;

(b) Operations and maintenance of the physical plant;

(c) Resident transportation;

(d) Dietary service (other than the cost of food and beverages);

(e) Laundry service;

(f) Medical and habilitative supplies;

(g) Taxes; and

(h) Insurance.

(2) An ICF/MR facility's administration and operations rate component is the lesser of:

(a) It's most recent reported cost per resident day adjusted for inflation; or

(b) The calculated rate that is at or above eighty-five percent of state and private facilities' most recent reported cost per resident day adjusted for inflation. This ranking must be based on cost reports used to determine rates for facilities with an occupancy level of at least eighty-five percent during the cost report period.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0680, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0685 How is the property rate component computed? (1) The property rate component reimburses an ICF/MR facility for the necessary and ordinary costs of leases, depreciation, and interest.

(2) It is the facility's most recent desk-reviewed cost per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0685, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0690 Does DSHS pay a return on equity to providers? DSHS pays a return on equity to proprietary providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0690, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0695 How is a return on equity calculated? Calculating return on equity is a three-step process.

(1) First, a provider's net equity is calculated using appropriate items from the provider's most recent cost report and relevant medicare rules and regulations. Note: Goodwill is not included in the calculation of net equity. Also, monthly equity calculations will not be used.

(2) Second, the medicare rate of return for the twelve-month period ending on the provider's cost report-closing date is multiplied by the provider's net equity.

(3) Finally, the amount calculated in subsection (2) is divided by the provider's annual resident days for the cost report period to determine a return on equity rate per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0695, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0700 What if a provider's cost report covers a period shorter than twelve months? If a provider's cost report covers less than a twelve-month period, annual resident days are estimated by using the actual resident days reported by the provider. The provider will then be paid a prospective rate per resident day. The prospective rate will either be the rate per resident day calculated in WAC 388-835-0010 or two dollars per resident day whichever is less.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0700, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0705 Are return on equity calculations subject to field audits? (1) All information used to calculate return on equity is subject to field audit.

(2) A field audit can be used to determine whether the providers reported equity exceeds the equity calculated according to medicare and the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0705, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0710 How does DSHS use field audit results? DSHS can use the field audit results to recalculate the provider's return on equity rate for the reported rate period. Any payments received by the provider in excess of the return on equity rate must be refunded to DSHS as part of the settlement procedure established in WAC 388-835-0720.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0710, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0715 Does DSHS place upper limits on the reimbursement rates it pays providers? DSHS limits its reimbursement rates to the following:

(1) Reimbursement rates for providers cannot exceed the provider's customary charge to the general public for the type of service covered by the rate.

(2) Public facilities rendering services for free or for a nominal charge will be reimbursed according to the methods and standards established in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0715, filed 4/20/01, effective 5/21/01.]

SETTLEMENTS

WAC 388-835-0720 What general requirements apply to settlements between DSHS and providers? (1) Except as otherwise provided in this chapter, settlements must be calculated at the lower of a provider's prospective reimbursement rate or audited allowable costs.

(2) Each provider must complete a proposed preliminary settlement as part of their annual cost report. The due date for the proposed preliminary settlement is the same as the due date for the annual cost report. After reviewing the proposed

preliminary settlement, DSHS must issue a preliminary settlement report to the provider.

(3) If a field audit is conducted, DSHS must evaluate the audit findings and issue a final settlement that incorporates the auditor's findings and DSHS's evaluation.

(4) If according to a preliminary or final settlement and the procedures in this chapter, a provider received overpayments from DSHS, they must refund those overpayments to the department. Conversely, DSHS must pay provider for any underpayments for which the department is responsible.

(5) Following a preliminary or final settlement, payment for services must be at the most recent available settlement rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0720, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0725 What requirements apply to paying overpayments and underpayments? (1) Within thirty days after submitting a preliminary or final settlement report to the provider, DSHS must pay any underpayments it owes.

(2) If a provider received overpayments or payments in error from DSHS, they must refund those payments within thirty days after receiving the preliminary or final settlement report.

(3) If a provider fails to comply with subsection (2) and the contract has not been terminated, DSHS must deduct the amount the provider owes, plus interest, from the department's current monthly payment due to the provider. The interest rate charged by DSHS on any unpaid balance is one percent per month.

(4) If a provider fails to comply with subsection (2) and the contract has been terminated, DSHS may:

(a) Deduct the amount owed by the provider, plus interest, from any amounts due to the provider from the department. (The interest rate on any unpaid balance is of one percent per month); or

(b) Use whatever legal means is available to recover the overpayment or erroneous payment plus interest on the unpaid balance at the rate of one percent per month.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0725, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0730 What if the amount of overpayment or underpayment is being disputed? (1) A provider does not have to refund any disputed amounts if they, in good faith, disagree with a settlement report and file a timely request for an administrative or judicial hearing.

(2) DSHS cannot withhold any amount owed by a provider, plus interest, from current payments due to the provider if the provider's debt is being administratively reviewed or judicially appealed.

(3) DSHS may recover portions of refunds and assess interest on amounts not specifically disputed by a provider in an administrative hearing or judicial appeal.

(4) If the administrative or judicial remedy sought by the provider is not granted or is partially granted after all appeals are exhausted or terminated by mutual agreement, the provider must refund all amounts owed to DSHS. These amounts, plus interest, must be paid within sixty days following the date of an administrative or judicial decision or the date the dispute process was mutually terminated. Interest accrues on the amount owed from the date a review was requested to the date the debt is repaid.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0730, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0735 What requirements apply to a provider's proposed preliminary settlement? (1) Proposed preliminary settlements submitted by providers must use the prospective rate for the resident care and habilitation cost center at which the provider was paid during the report period, including any resident specific payment adjustments. Resident specific payments must be weighted by the number of paid resident days each rate was in effect and compared to the provider's allowable costs for the cost center divided by total resident days.

(2) A provider's administration, operations, and property cost center settlement rate must be the prospective rate for the report period, including any payment adjustments, weighted by the number of paid resident days each rate was in effect.

(3) A provider's return on equity settlement rate must be the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0735, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0740 How must DSHS respond to a provider's proposed preliminary settlement? (1) DSHS has one hundred twenty days after receiving a proposed preliminary settlement to review it for accuracy and either accept or reject it.

(2) If accepted, the proposed preliminary settlement becomes the preliminary settlement report.

(3) If rejected, DSHS must issue a preliminary settlement report by cost center that fully substantiates disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0740, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0745 What recourse does a provider have if DSHS rejects their proposed preliminary settlement? A provider has thirty days after receiving a preliminary settlement report to contest it (see WAC 388-835-0950 and 388-835-0955). After thirty days, if the preliminary settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0745, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0745, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0750 What requirements apply to final settlements? (1) A final settlement must be by cost center and must fully substantiate all:

(a) Disallowed costs;

(b) Refunds;

(c) Underpayments; or

(d) Adjustments to cost reports, financial statements, other reports, and schedules submitted by the provider.

(2) A final settlement report must use the prospective rate at which the provider was paid during the report period,

including any resident specific payment adjustments made for resident care and training cost center. Resident specific payments must be weighted by the number of paid resident days reported for the period each rate was in effect. DSHS must compare these payments to the provider's audited allowable costs for the period.

(3) A provider's administration operations and property cost center settlement rate is the prospective rate for the period weighted by the number of paid resident days each rate was in effect.

(4) A provider's return of equity rate is the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0750, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0755 Can a provider disagree with a final settlement report? A provider has thirty days after receiving a final settlement report to contest it (see WAC 388-835-0950 and 388-835-0955). After thirty days, if the final settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0755, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0755, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0760 What if DSHS conducts an audit during the final settlement process? (1) If DSHS conducts an audit, it must issue a final settlement report to the provider after the audit process is completed. Completing the audit process includes exhausting or mutual terminating the reviews and/or appeals of audit findings or determinations.

(2) If a provider, in good faith, is disputing audit findings or determinations through the administrative review or judicial appeal process, DSHS may issue a partial final settlement report to recover overpayments based on audit findings or determinations not being disputed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0760, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0765 Why is a state facility settlement important? The state facility settlement is determined to establish a state facility's final payment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0765, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0770 How is a state facility settlement calculated? The settlement must be calculated as follows:

(1) If the state facility's allowable costs for the report period are greater than their interim payment, the amount owed to the facility is the allowable cost amount minus the interim payment.

(2) If the state facility's allowable costs for the report period are less than their interim payment, the amount owed by the department is the interim payment minus the allowable cost amount.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0770, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0775 How is a state facility settlement implemented? (1) The settlement is implemented in a two-step process consisting of the facility first submitting a proposed preliminary settlement to DSHS and DSHS responding with a final settlement report that it submits to the state facility.

(2) The proposed preliminary settlement must be:

(a) Submitted to DSHS when the state facility submits their cost report.

(b) Responded to by DSHS within one hundred twenty days after they receive it from the state facility. DSHS must verify the accuracy of the facility's proposal and issue a preliminary settlement substantiating the settlement amount.

(3) The final settlement is the preliminary settlement issued by DSHS if an audit is not conducted.

(4) If an audit is conducted, DSHS must submit a final settlement report to the state facility after the audit process is completed. This report must substantiate all disallowed costs, refunds, underpayments, or adjustments to the provider's financial statements, cost report, and final settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0775, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0780 Does DSHS have a responsibility to notify each provider regarding prospective reimbursement rates? (1) DSHS must give written notification to each provider regarding DSHS's prospective reimbursement rate.

(2) Unless specified at the time the reimbursement rate is issued, the rate will be effective from the first day of the month the rate is issued until a new rate becomes effective.

(3) If a rate is changed because of a successful provider appeal, the effective date of the new rate is the same as the effective date of the old rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0780, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0785 Can DSHS increase prospective reimbursement rates? (1) Except for the situations described in subsection (3) and (4) of this section, DSHS prospective reimbursement rates are the maximum provider payment rates for those periods to which they apply.

(2) DSHS does not grant rate adjustments for cost increases that are or were subject to management control or negotiations. Examples include, but are not limited to, all lease cost increases or any cost increases not expressly authorized in subsection (3) and (4).

(3) DSHS does adjust rates for any capitalized additions or replacements made as a condition for licensure or certification.

(4) DSHS does adjust rates for cost increases that must be incurred and cannot be met through the provider's prospective rate. Examples of such cost increases are:

(a) Program changes required by DSHS;

(b) Changes in staffing levels or consultants at a facility required by DSHS;

(c) Changes required by a survey; and

(d) Changes in revenue assessments required by the state legislature.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0785, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0790 How does a provider request a rate increase? (1) Any provider requesting a rate adjustment must submit a:

(a) Financial analysis showing the increased cost and an estimate of the rate increase needed to cover the increased cost. The estimated rate increase must be computed according to allowable methods;

(b) Written justification for granting the rate increase; and

(c) Certification and documentation that show the staffing changes and/or other improvements started or completed.

(2) Provider's requesting adjustments under WAC 388-835-0900 must submit a written plan identifying the staff they are going to add and the resident needs they have not met because of insufficient staffing.

(3) When reviewing provider requests made under WAC 388-835-0900, DSHS considers:

(a) If the additional staff requested by a provider is appropriate for meeting resident needs;

(b) Staffing level comparisons with facilities having similar characteristics;

(c) The facility's physical layout;

(d) Supervision and management of current staff;

(e) Historical trends regarding the facility's underspending for resident care and habilitation;

(f) Number and position of existing staff; and

(g) Other resources available to the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0790, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0795 What requirements apply to providers who receive rate increases? (1) Providers that receive prospective rate increases may be required to submit quarterly reports showing how the additional funds were spent. If required, a quarterly report would begin on the first day of the month following the date the rate increase is granted.

(2) If the additional funds resulting from the rate increase are not spent on DSHS approved changes or improvements approved, DSHS may ask that they be returned immediately.

(3) If a facility gives written notice to DSHS that it intends to close by a specific date and that returning the funds would jeopardize its ability to provide for the health, safety, and welfare of its residents, it may not have to return the additional funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0795, filed 4/20/01, effective 5/21/01.]

ERRORS AND OMISSIONS

WAC 388-835-0800 What if DSHS discovers that a prospective rate calculation was affected by an error or omission? (1) DSHS may adjust prospective rates resulting from cost report errors, computational errors or omissions by either DSHS or the provider.

(2) In addition to adjusting the rate, DSHS must notify the provider in writing:

(a) Regarding the nature and substance of each adjustment;

(b) That the effective date of each adjustment is the same as the effective date of the original rate; and

(c) Of any amount due to either DSHS or the provider as a result of an adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0800, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0805 What if a provider discovers an error or omission that affected their cost report? (1) If a provider discovers an error or omission that caused their cost report to be incorrect, the provider must submit amended cost report pages.

(2) Amended cost report pages must be certified and accompanied by a written explanation why the amendment is necessary. Amendments are not accepted by DSHS unless they comply with the requirements in WAC 388-835-0815.

(3) If DSHS concludes that the amendment changes are material, the amended pages must be audited by a field audit.

(4) If DSHS concludes that the amendments are incorrect or unacceptable as a result of the field audit or other information it receives, any rate adjustment based on the amendments is null and void. Any scheduled future rate payment increases resulting from the amendments must be canceled immediately.

(5) Any rate adjustment payments must be made according to the repayment provisions in WAC 388-835-0905.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0805, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0810 What other requirements apply to rate adjustments resulting from errors or omissions? (1) No adjustment can be made to a rate more than:

(a) One hundred twenty days after the field audit narrative and summary is sent to the provider; or

(b) One hundred twenty days after a preliminary settlement becomes a final settlement.

(2) A final settlement that is concluded within the one hundred twenty-day time limits could only be reopened to adjust prospective rates that are based upon errors or omissions.

(3) Only adjustments to prospective rates (and the related computations) resulting from errors or omissions can be reviewed if a timely request is filed according to the provisions of WAC 388-835-0950.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0810, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0815 What requirements apply to repayment of amounts owed due to errors or omissions? (1) Repayment (or starting repayment) of any amount owed to DSHS by a provider as a result of an error or omission rate adjustment must occur:

(a) Within sixty days after the provider receives a rate adjustment notification from DSHS; or

(b) According to a repayment schedule developed by DSHS.

(2) If a provider does not repay its debt to DSHS when it is due, DSHS may deduct the amount owed from the providers current DSHS payment.

(3) If a provider unsuccessfully contests the rate adjustment (see WAC 388-835-0950, they must repay DSHS (or

start repayment) within sixty days after the administrative or judicial proceedings are completed.

(4) If DSHS owes a provider as a result of a rate adjustment, DSHS must pay the provider within thirty days after notifying the provider of the adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0815, filed 4/20/01, effective 5/21/01.]

PUBLIC REVIEW—PUBLIC DISCLOSURE

WAC 388-835-0820 What role does the public play in setting prospective reimbursement rates? Each year before prospective reimbursement rates are set, DSHS will give all interested members of the public an opportunity to review and comment on the department's proposed rate setting methods and standards.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0820, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0825 What is DSHS' public disclosure responsibility regarding rate setting methodology? Without identifying individual ICF/MR facilities and in compliance with public disclosure statute and rule requirements, DSHS will provide the public with full and complete information regarding its rate setting methodology.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0825, filed 4/20/01, effective 5/21/01.]

BILLING PROCEDURES AND PAYMENTS

WAC 388-835-0830 How does a provider bill DSHS for services provided? (1) A provider must bill DSHS each month, from the first through the last day, for care provided to medical care recipients by completing and returning an IMR statement filed according to department instructions.

(2) A provider cannot bill DSHS for services provided to a resident until they receive a DSHS resident award letter. When the provider receives the award letter, they can bill for services provided since the resident's admission or eligibility date.

(3) A provider cannot bill DSHS for the day of a resident's death, discharge, or transfer from the ICF/MR facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0830, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0835 How does DSHS pay a provider? (1) DSHS will reimburse a provider for billed service rendered under the ICF/MR contract according to the appropriate rate assigned to the provider.

(2) For each resident, DSHS will pay an amount equal to the appropriate rates multiplied by the number of resident days each rate was in effect, less any amount a resident is required to pay (see WAC 388-835-0940).

(3) A provider must accept DSHS's reimbursement rates as full compensation for all services the provider is obligated to provide under their contract. The provider must not seek or accept additional compensation any contracted services from or on behalf of a resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0835, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0840 Can DSHS withhold provider payments? DSHS cannot withhold a provider payment until the provider is given written notification explaining why the payment is being withheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0840, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0845 Can DSHS terminate medicaid Title XIX payments to providers? DSHS must terminate all medicaid Title XIX payments to a provider no later than sixty days after a:

(1) Contract expires, is terminated or is not renewed;

(2) Facility license is revoked; or

(3) Facility is decertified as a Title XIX facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0845, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0850 Who is responsible for collecting from residents any amounts they may own for their care? (1) DSHS will notify a provider of the amount each resident is required to pay for care provided under the contract and the date the payment is due.

(2) The provider is responsible for:

(a) Collecting from the resident; and

(b) Accounting for, according to procedures established by DSHS, any authorized reduction in the resident's contribution.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0850, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0855 What if a resident's circumstances change causing a provider to contribute more to the resident's care? (1) If a provider receives documentation verifying a change in a resident's income or resources that will reduce the resident's ability to contribute to the cost of their care, the provider must report this information in writing to the DDD regional services office within seventy-two hours.

(2) Any necessary corrections should be made in the next ICF/MR statement and a copy of the supporting documentation should be attached.

(3) If a provider receives increased funds for a resident, the normal amount must be allowed for clothing, personal, and incidental expenses and the balance must be applied to the cost of care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0855, filed 4/20/01, effective 5/21/01.]

RECEIVERSHIP

WAC 388-835-0860 What is the role of a receiver when an ICF/MR facility is placed in receivership? If an ICF/MR facility is providing care to state medical assistance recipients and is placed under receivership, the receiver:

(1) Becomes the medicaid provider during the receivership period;

(2) Assumes all new provider reporting responsibilities;

(3) Assumes all other new provider responsibilities established in this chapter; and

(4) Is responsible, during the receivership period, for refunding any medicaid rate payments received that exceed cost of services provided.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0860, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0865 How does DSHS determine prospective reimbursement rates during receivership? When establishing prospective reimbursement rates during receivership, DSHS must consider:

(1) Court ordered compensation, if any, for the receiver. Receiver compensation may already be available through the:

(a) Return on equity cost center rate, or

(b) Facility administrator salary where the receiver is also the facility's administrator.

(c) In order to satisfy the court order when existing sources of compensation are less than the compensation ordered by the court, DSHS could consider the difference as an additional allowable cost when establishing prospective reimbursement rates.

(2) Start-up costs and costs of repairs, replacements, and additional staff needed for resident health, training, security, and welfare. No additional money will be added to the rate if these costs can be covered through the return on equity cost center rate; and

(3) Any other allowable costs contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0865, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0870 What if the court asks DSHS to recommend a receiver's compensation? If asked for a recommendation regarding receiver compensation by the court, DSHS must consider the:

(1) Range of compensation for private ICF/MR facility managers;

(2) Experience and training of the receiver;

(3) Size, location, and current condition of the facility; and

(4) Additional factors considered appropriate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0870, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0875 Can DSHS give emergency or transitional financial assistance to a receiver? (1) In response to a court order, DSHS must give up to thirty thousand dollars of emergency or transitional financial assistance to a receiver.

(2) DSHS must recover any emergency or transitional assistance given to a receiver from facility generated revenue that is not obligated for facility operations.

(3) If DSHS has not fully recovered the emergency or transitional assistance when the receivership ends, DSHS may file:

(a) An action against the former licensee or owner to recover what is owed; or

(b) A lien against the facility or the proceeds from the sale of the facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0875, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0880 What happens when a receivership ends? When a receivership ends, DSHS may revise the facility's medicaid reimbursement as follows:

(1) The medicaid reimbursement rate for the former owner or licensee must be what it was before receivership unless the former owner or licensee requests prospective rate revisions according to the requirements of this chapter.

(2) The medicaid reimbursement rate for licensed replacement operators must be established according to the rules in this chapter governing prospective reimbursement rates for new providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0880, filed 4/20/01, effective 5/21/01.]

DISPUTE RESOLUTION

WAC 388-835-0885 What disputes between providers and DSHS can be resolved through the administrative review process? A provider can use the administrative review process to contest:

(1) An "errors or omissions" reimbursement rate adjustment issued to the provider (see WAC 388-835-0845) or DSHS's refusal to adjust a rate the provider believes is incorrect due to errors or omissions. The provider must request an administrative review within thirty days of receiving notification that a rate has been adjusted or that DSHS refuses to adjust the rate.

(2) The way in which a DSHS rule, contract provision, or policy statement was applied when calculating the provider's prospective cost related reimbursement system's rate.

(3) An audit finding, other audit determination, a rate review or other settlement determination.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0885, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0890 What disputes cannot be resolved through the administrative review and fair hearing processes? DSHS' administrative review and fair hearing processes cannot be used to challenge the adequacy of any prospective or settlement reimbursement rate or rate component, either individually or collectively.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0890, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0900 How does a provider request an administrative review? (1) A provider challenging an audit or settlement determination has a maximum of thirty days after receiving the finding or decision to file a written request for an administrative review.

(2) Written requests must be filed with the:

(a) Office of financial recovery services when the provider challenges an audit finding (adjusting journal entries or AJEs) or other audit determination; or

(b) DDD director when the provider challenges a rate, desk review, or other settlement determination.

(3) The written request must:

(a) Be signed by the provider or facility administrator;

(b) Identify the specific determination being challenged and the date it was issued;

(c) State, as specifically as possible, the issues and regulations involved and why the provider claims the determination was erroneous; and

(d) Be accompanied by any documentation that will be used to support the provider's position.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0900, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0905 What happens after a provider requests an administrative review? (1) After receiving a provider's request, DSHS must schedule a conference between the provider and appropriate department representatives.

(2) Unless both parties agree, in writing, to a specific later date, the conference must be scheduled at least fourteen days after DSHS notifies the provider that a conference will be held and no later than ninety days after DSHS receives the provider's review request.

(3) The conference may be conducted by telephone unless DSHS or the provider requests, in writing, that it be held in person.

(4) The provider and DSHS representatives must participate in the conference.

(5) Either at the conference or before, the provider must give DSHS any documentation:

(a) Requested by DSHS that the provider is required to maintain for audit purposes under WAC 388-835-0270; and

(b) The provider intends to use to support their position.

(6) At the conference DSHS and the provider must clarify the issues and attempt to resolve them.

(7) If additional documentation is necessary to resolve the issues, a second conference meeting must be scheduled. Unless both parties agree, in writing, to a specific later date, this second conference meeting must be scheduled not later than thirty days after the first session.

(8) Regardless of whether an agreement is reached, DSHS must give the provider a written decision within sixty days after the conference ends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0905, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0910 What if a provider disagrees with the administrative review decision? (1) If they disagree with the administrative review decision, a provider has a right to request an adjudicative proceeding within thirty days of receiving the decision.

(2) To request an adjudicative proceeding, a provider must:

(a) File a written request with the office of administrative hearings (OAH);

(b) Sign the request or have it signed by the facility administrator;

(c) State as specifically as possible the issues and regulations involved;

(d) State the reasons for disagreeing with the administrative review decision; and

(e) Attach a copy of the contested decision and any documentation the provider will use to support their position.

(3) The adjudicative proceeding must be governed by the Administrative Procedure Act (chapter 34.05 RCW), this chapter, and chapter 388-02 WAC. If any part of this chapter conflict with chapter 388-02 WAC, this chapter prevails.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0910, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0915 Can DSHS withhold an undisputed overpayment amount from a current ICF/MR payment? DSHS is authorized to withhold from an ICF/MR's current payment all amounts found by a preliminary or final settlement to be overpayments if they are not identified by the ICF/MR as overpayments and challenged in an administrative or judicial review.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0915, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0920 Can DSHS withhold a disputed overpayment amount from a current ICF/MR payment? Once administrative and judicial review processes are complete, contested overpayments retained by an ICF/MR may be withheld from the ICF/MR's current payment but only to the extent DSHS's position or claims are upheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0920, filed 4/20/01, effective 5/21/01.]

COST OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS

WAC 388-835-0925 What is the purpose of this section? The purpose of this chapter is to regulate the costs of care of mentally/physically deficient persons.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0925, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0930 How is the payment for residential facilities set? The department sets the payment for residential facilities by the methodology noted in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0930, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0935 How much of a resident's income is exempt from paying their care? Residents whose total resources are insufficient to pay the actual cost of care must be entitled to a monthly exemption from income in the amount of twenty-five dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0935, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0940 What if the estate of a resident is able to pay all or a portion of their monthly cost? (1) If DSHS finds that the estate of a resident is able to pay all or a portion of their monthly costs for care, support, and treatment, they must serve a written notice of finding of responsibility (NFR) on the:

(a) Guardian of the resident's estate; or

(b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative capacity and in possession of the resident's property; and

(c) The superintendent of the state school.

(2) If a resident is an adult and is not under a legal disability, the department must personally serve the NFR on the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0940, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0945 If a resident or guardian is served by DSHS with a NFR when is payment due? If a resident or guardian is served by DSHS with an NFR, payment is due thirty days after receiving the notice.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0945, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0950 May a resident or guardian request a hearing if they disagree with the NFR? If a resident or guardian disagrees with the NFR, they have the right to ask for a hearing under chapter 34.05 RCW. They must file a written hearing request within thirty days of receipt with the secretary of DSHS, ATTN: Determination Officer, P.O. Box 9768, Olympia, WA 98504.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0950, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0955 What information must be included in the request for a hearing? The request for hearing must include:

(1) A specific statement of the issues and law involved;

(2) The grounds for contesting the department decision; and

(3) A copy of the NFR being contested.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0955, filed 4/20/01, effective 5/21/01.]

Chapter 388-837 WAC

RESIDENTIAL HABILITATION CENTER (RHC) ICF/MR PROGRAM

WAC

WAC 388-837-9005 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules authorized by Title 71A RCW for RHC ICF/MR programs, rules that:

(a) Regulate the purchase and provision of services in state operated intermediate care facility for the mentally retarded (ICF/MR); and

(b) Assure adequate ICF/MR care, service, and protection are provided through certification procedures; and

(c) Establish standards for providing habilitative training, health-related care, supervision, and residential services to eligible persons.

(2) Except where specifically referenced, this chapter supersedes and replaces any and all sections affecting ICF/MR facilities or programs contained in chapter 388-96 WAC.

(3) Except as referenced, definitions in WAC 388-835-0010 apply to this chapter.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9005, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9015 What does a transfer from one RHC to another RHC mean? A transfer means the discharge of a resident from the current RHC in which the resident resides and the admission of that resident to another RHC.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9015, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9020 Do residents have a right to a hearing when transferring from a residential habilitation center (RHC) to another RHC? Notwithstanding hearing rights set forth in WAC 388-825-120 (1)(d), there is no right to an adjudicative proceeding for a resident when the department concludes that the facility where the resident resides cannot provide services due to:

(1) Decertification of the RHC;

(2) Revocation of the RHC's certification; or

(3) An emergency suspension of the RHC's certification;

(4) Partial closure of the RHC; or

(5) Closure of the RHC.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9020, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9030 What rights are available to a resident regarding a proposed transfer from one RHC to another RHC? (1) A resident, their guardian, next-of-kin, or responsible party must be notified in writing at least thirty days before any transfer occurs.

(2) The transfer notice must include the reason for the proposed transfer.

(3) A resident, their guardian, next of kin, or responsible party has a right to an informal administrative review before the division director or designee.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9030, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9040 What rights are available to a resident regarding a proposed transfer from an RHC to the community, per RCW 71A.20.080? (1) A resident, or the resident's authorized representative has a right to a hearing regarding the proposed transfer from an RHC to the community, per RCW 71A.20.080 and under chapter 34.05 RCW and chapter 388-02 WAC. DSHS must send a hearing request form with the notice of transfer.

(2) If the resident requests a hearing within the thirty-day time period, DSHS may not transfer the resident until a hearing decision is reached or appeal rights have been exhausted unless the transfer is warranted by the resident's health or safety needs or the welfare of the other residents.

(3) If the secretary or the secretary's designee concludes that the transfer is not appropriate, no further action is to be taken to transfer unless there is a change in the situation or circumstances surrounding the transfer request. If there is a change in the situation or circumstances, the request may be resubmitted.

(4) If the secretary or the secretary's designee affirms the decision to transfer the resident and no petition for judicial review is filed within thirty days, DSHS may proceed with the planned action.

(5) If the secretary or secretary's designee affirms the decision to transfer the resident and a petition for judicial review has been filed, any proposed transfer must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety or the welfare of other residents, or as otherwise provided in RCW 71A.20.080.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9040, filed 7/23/04, effective 8/23/04.]

Chapter 388-840 WAC

WORK PROGRAMS FOR RESIDENTS OF RESIDENTIAL HABILITATION CENTERS IN THE DIVISION OF DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-41 WAC)

WAC

WAC 388-840-005 Purpose. The regulations provide guidelines for the operation of work programs at residential habilitation centers or for programs contracted on behalf of residents of residential habilitation centers within the division of developmental disabilities as required under RCW 43.20A.445.

[99-19-104, recodified as § 388-840-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-005, filed 8/9/91, effective 9/9/91.]

WAC 388-840-010 Definition. (1) "Compensate" means the resident's receipt of money for work done at a work program.

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

(3) "Division" means the developmental disabilities division of the department of social and health services.

(4) "Prevailing wage" means the amount paid to a nondisabled worker in a nearby industry or surrounding community for essentially the same type, quality, and quantity of work or work requiring comparable skills.

(5) "Residential habilitation center (RHC)" means a residential habilitation center operated by the developmental disabilities division.

(6) "Work program" means a directed vocational activity or series of related activities provided on a systematic, organized basis for developing and maintaining individual resident work skills, and providing remuneration to resident employees. Work programs must result in:

(a) Benefit to the economy of the facility; or

(b) A contribution to the facility's maintenance; or

(c) Produce articles or services for sale.

[99-19-104, recodified as § 388-840-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-010, filed 8/9/91, effective 9/9/91.]

WAC 388-840-015 Establishment of new work programs. The requirements of RCW 43.20A.445 shall be followed before the department establishes new residential habilitation center work programs.

[99-19-104, recodified as § 388-840-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-015, filed 8/9/91, effective 9/9/91.]

WAC 388-840-020 Protection of residents. (1) When a resident participates in a work program, the resident shall be employed in work and subjected to work conditions where reasonable precautions are taken to ensure the resident's health and safety.

(2) Resident work programs shall be consistent with the resident's individual habilitation plan objectives.

[99-19-104, recodified as § 388-840-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-020, filed 8/9/91, effective 9/9/91.]

WAC 388-840-025 Compensation for persons participating in work programs. (1) The department shall compensate a person participating in a work program at the prevailing minimum wage except when an appropriate certificate has been obtained by the RHC or contract program in accordance with current regulations and guidelines issued under the Fair Labor Standards Act (29 CFR Ch. V, 525 and 529) as amended.

(2) The department shall not be required to compensate a person participating in the shared domiciliary activities of maintaining the person's own immediate household or residence.

[99-19-104, recodified as § 388-840-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-025, filed 8/9/91, effective 9/9/91.]

Chapter 388-845 WAC

DDD HOME AND COMMUNITY BASED SERVICES WAIVERS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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.

388-845-0080 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.

388-845-0085 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.

388-845-0090 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.

388-845-0095 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.

"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; stepbrother; stepsister; uncle; aunt; first cousin; niece; or nephew.

"Gainful employment" means employment that reflects achievement of or progress towards a living wage.

"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.

"Integrated settings" mean typical community settings not designed specifically for individuals with disabilities in which the majority of persons employed and participating are individuals without disabilities.

"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.

"Living wage" means the amount of earned wages needed to enable an individual to meet or exceed his/her living expenses.

"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. 08-20-033, § 388-845-0001, filed 9/22/08, effective 10/23/08; 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 388-845-0005 What are home and community based services (HCBS) waivers? (1) Home and community based services (HCBS) waivers are services approved by the Centers For Medicare and Medicaid Services (CMS) under section 1915 (c) of the Social Security Act as an alternative to intermediate care facility for the mentally retarded (ICF/MR) care.

(2) Certain federal regulations are "waived" enabling the provision of services in the home and community to individuals who would otherwise require the services provided in an ICF/MR as defined in chapters 388-835 and 388-837 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0010 What is the purpose of HCBS waivers? The purpose of HCBS waivers is to provide services in the community to individuals with ICF/MR level of need to prevent their placement in an ICF/MR.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0010, 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 388-845-0020 When were these four HCBS waivers effective? The four DDD HCBS waivers were effective April 1, 2004.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0020, 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 identified health and welfare 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 or in their own home.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-0045, filed 9/22/08, effective 10/23/08; 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 388-845-0051 How will I be notified of the decision by DDD to enroll me in a waiver? DDD will notify you in writing of its decision to enroll you in a waiver or its decision to deny your request to be enrolled in a waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0051, 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 388-845-0065 What happens if I am terminated or choose to disenroll from a waiver? If you are terminated from a waiver or choose to disenroll from a waiver, DDD will notify you.

(1) DDD cannot guarantee continuation of your current services, including medicaid eligibility.

(2) Your eligibility for nonwaiver state-only funded DDD services is based upon availability of funding and program eligibility for a particular service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0065, 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 388-845-0115 Does my waiver eligibility limit my access to DDD nonwaiver services? If you are enrolled in a DDD HCBS waiver:

(1) You are not eligible for state-only funding for DDD services; and

(2) You are not eligible for medicaid personal care.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0115, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0120 Will I continue to receive state supplementary payments (SSP) if I am on the waiver? Your participation in the new waivers does not affect your continued receipt of state supplemental payment from DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0120, filed 12/13/05, effective 1/13/06.]

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 $6804 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. 08-20-033, § 388-845-0205, filed 9/22/08, effective 10/23/08; 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 $9944 per year This amount may be increased to a maximum of $19,888 per year by exception to rule based on client need

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	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. 08-20-033, § 388-845-0210, filed 9/22/08, effective 10/23/08; 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 Residential habilitation Community access Person-to-person Prevocational services Supported employment	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
	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 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	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

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
	Prevocational services Supported employment	
	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.]

WAIVER SERVICES DEFINITIONS

WAC 388-845-0300 What are adult family home (AFH) services? Per RCW 70.128.010 an adult family home (AFH) is a regular family abode 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 service. Adult family homes (AFH) may provide residential care to adults in the Basic Plus waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0300, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0305 Who is a qualified provider of AFH services? The provider of AFH services must be licensed and contracted with ADSA as an AFH who has successfully completed the DDD specialty training provided by the department.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0305, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0310 Are there limits to the AFH services I can receive? Adult family homes services are limited by the following:

(1) AFH services are defined and limited per chapter 388-106 WAC and chapter 388-71 WAC governing medicaid personal care and the comprehensive assessment and reporting evaluation (CARE).

(2) Rates are determined by and limited to department published rates for the level of care generated by CARE.

(3) AFH reimbursement cannot be supplemented by other department funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0310, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0400 What are adult residential care (ARC) services? Adult residential care (ARC) facilities may provide residential care to adults. This service is available in the Basic Plus waiver.

(1) An ARC is a licensed boarding home for seven or more unrelated adults.

(2) Services include, but are not limited to, individual and group activities; assistance with arranging transportation; assistance with obtaining and maintaining functional aids and equipment; housework; laundry; self-administration of medications and treatments; therapeutic diets; cuing and providing physical assistance with bathing, eating, dressing, locomotion and toileting; stand-by one person assistance for transferring.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0400, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0405 Who is a qualified provider of ARC services? The provider of ARC services must:

(1) Be a licensed boarding home;

(2) Be contracted with ADSA to provide ARC services; and

(3) Have completed the required and approved DDD specialty training.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0405, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0410 Are there limits to the ARC services I can receive? ARC services are limited by the following:

(1) ARC services are defined and limited by boarding home licensure and rules in chapter 388-78A WAC, and chapter 388-106 WAC and chapter 388-71 WAC governing medicaid personal care and the comprehensive assessment and reporting evaluation (CARE).

(2) Rates are determined and limited to department published rates for the level of care generated by CARE.

(3) ARC reimbursement cannot be supplemented by other department funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0410, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0500 What is behavior management and consultation? (1) Behavior management and consultation may be provided to persons on any of the four HCBS waivers and include the development and implementation of programs designed to support waiver participants using:

(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and

(b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling).

(2) Behavior management and consultation may also be provided as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0500, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0505 Who is a qualified provider of behavior management and consultation? The provider of behavior management and consultation must be one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

(1) Marriage and family therapist;

(2) Mental health counselor;

(3) Psychologist;

(4) Sex offender treatment provider;

(5) Social worker;

(6) Registered nurse (RN) or licensed practical nurse (LPN);

(7) Psychiatrist;

(8) Psychiatric advanced registered nurse practitioner (ARNP);

(9) Physician assistant working under the supervision of a psychiatrist;

(10) Registered counselor; or

(11) Polygrapher.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0505, 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 388-845-0600 What are community access services? Community access services are provided in the community to enhance or maintain your community integration, physical or mental skills.

(1) If you are age sixty-two or older, these services are available to assist you to participate in activities, events and organizations in the community in ways similar to others of retirement age.

(2) 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. 08-20-033, § 388-845-0600, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0600, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0605 Who are qualified providers of community access services? Providers of community access services must be a county or an individual or agency contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-0605, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0605, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0610 Are there limits to community access services I can receive? The following limits apply to your receipt of community access services:

(1) You must be age sixty-two or older.

(2) You cannot be authorized to receive community access services if you receive prevocational services or supported employment services.

(3) The dollar limitations for employment/day program 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. 08-20-033, § 388-845-0610, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0610, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0700 What is a community guide service? Community guide service increases access to informal community supports. Services are short-term and designed to develop creative, flexible and supportive community resources for individuals with developmental disabilities. This service is available in Basic, Basic Plus and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0700, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0705 Who is a qualified community guide? Any individual or agency contracted with DDD as a "community guide" is qualified to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0705, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0710 Are there limitations to the community guide services I can receive? (1) You may not receive community guide services if you are receiving residential habilitation services as defined in WAC 388-845-1500 because your residential provider can meet this need.

(2) 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.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0710, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0750 What are community transition services? (1) Community transition services are reasonable costs (necessary expenses in the judgment of the state for you to establish your basic living arrangement) associated with moving from:

(a) An institutional setting to a community setting in which you are living in your own home or apartment, responsible for your own living expenses and receiving services from a DDD certified residential habilitation services provider as defined in WAC 388-845-1505 and 388-845-1510; or

(b) A provider operated setting, such as a group home, staffed residential, or companion home in the community to a community setting in which you are living in your own home or apartment, responsible for your own living expenses, and receiving services from a DDD certified residential habilitation services provider as defined in WAC 388-845-1505 and 388-845-1510.

(2) Community transition services include:

(a) Security deposits (not to exceed the equivalent of two month's rent) that are required to obtain a lease on an apartment or home;

(b) Essential furnishings such as a bed, a table, chairs, window blinds, eating utensils and food preparation items;

(c) Moving expenses required to occupy your own home or apartment;

(d) Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); and

(e) Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

(3) Community transition services are available in the CORE and community protection waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-0750, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0750, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0755 Who are qualified providers of community transition services? (1) Providers of community transition services for individuals in the CORE waiver must meet the requirements as a provider of residential habilitation services contained in WAC 388-845-1505.

(2) Providers of community transition services for individuals in the community protection waiver must meet the requirements as a provider of residential habilitation services contained in WAC 388-845-1510.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0755, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0760 Are there limitations to community transition services I can receive? (1) Community transition services do not include:

(a) Diversional or recreational items such as televisions, cable TV access, VCRs, MP3, CD or DVD players; and

(b) Computers if primarily used as a diversional or for recreation.

(2) Rent assistance is not available as a community transition service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-0760, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0760, 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 388-845-0805 Who is a qualified provider of emergency assistance? The provider of the service you need to meet your emergency must meet the provider qualifications for that service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0805, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0810 How do I qualify for emergency assistance? You qualify for emergency assistance only if you have used all of your waiver funding and your current situation meets one of the following criteria:

(1) You involuntarily lose your present residence for any reason either temporary or permanent;

(2) You lose your present caregiver for any reason, including death;

(3) There are changes in your caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the individual; or

(4) There are significant changes in your emotional or physical condition that requires a temporary increase in the amount of a waiver service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0810, 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 388-845-0905 Who is a qualified provider for building these environmental accessibility adaptations? The provider making these environmental accessibility adaptations must be a registered contractor per chapter 18.27 RCW and contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0905, 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 388-845-1000 What are extended state plan services? Extended state plan services refer to physical therapy; occupational therapy; and speech, hearing and language services available to you under medicaid without regard to your waiver status. They are "extended" services when the waiver pays for more services than is provided under the state medicaid plan. These services are available under all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1010 Who is a qualified provider of extended state plan services? Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDD for the therapy they are providing.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1015 Are there limits to the extended state plan services I can receive? (1) Additional therapy may be authorized as a waiver service only after you have accessed what is available to you under medicaid and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service you can receive:

(a) The department reserves the right to require a second opinion from a department-selected provider.

(b) The department will require evidence that you have accessed your full benefits through medicaid and private insurance before authorizing this waiver service.

(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.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1100 What are mental health crisis diversion bed services? Mental health crisis diversion bed services are temporary residential and behavioral services that may be provided in a client's home or licensed or certified setting. These services are available to eligible clients who are at risk of serious decline of mental functioning and who have been determined to be at risk of psychiatric hospitalization. These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1105 Who is a qualified provider of mental health crisis diversion bed services? Providers of mental health crisis diversion bed services must be:

(1) DDD certified residential agencies per chapter 388-101 WAC; or

(2) Other department licensed or certified agencies.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1110 What are the limits of mental health crisis diversion bed services? (1) Mental health crisis diversion bed services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

(3) The costs of mental health crisis diversion bed services do not count toward the dollar limits for aggregate services in the Basic and Basic Plus waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1150 What are mental health stabilization services? Mental health stabilization services assist persons who are experiencing a mental health crisis. These services are available in all four waivers to adults determined by mental health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one of more of the following services:

(1) Behavior management and consultation;

(2) Skilled nursing services;

(3) Specialized psychiatric services; or

(4) Mental health crisis diversion bed services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1150, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1155 Who are qualified providers of mental health stabilization services? Providers of these mental health stabilization services are listed in the rules in this chapter governing the specific services listed in WAC 388-845-1150.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1155, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1160 Are there limitations to the mental health stabilization services that I can receive? (1) Mental health stabilization services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) The costs of mental health stabilization services do not count toward the dollar limitations for aggregate services in the Basic and Basic Plus waiver.

(3) Mental health stabilization services require prior approval by DDD or its designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1160, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1200 What are "person-to-person" services? (1) "Person-to-person" services are intended to assist you to achieve the outcome of gainful employment in an integrated setting through a combination of services, which may include:

(a) Development and implementation of self-directed employment services;

(b) Development of a person centered employment plan;

(c) Preparation of an individualized budget; and

(d) Support to work and volunteer in the community, and/or access the generic community resources needed to achieve integration and employment.

(2) These services may be provided in addition to community access, prevocational services, or supported employment.

(3) These services are available in all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1200, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1205 Who are qualified providers of person-to-person services? Providers of "person-to-person" services must be a county or an individual or agency contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1205, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1205, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1210 Are there limits to the person-to-person service I can receive? (1) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school or age twenty-two or older to receive person-to-person services.

(2) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

(3) These services will be provided in an integrated environment.

(4) Your service hours are determined by the level of assistance you need to reach your employment outcomes and might not equal the number of hours you spend on the job or in job related activities.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1210, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1210, 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 388-845-1305 Who are the qualified providers of personal care services? (1) Qualified providers of personal care services may be individuals or licensed homecare agencies contracted with ADSA.

(2) All individual providers and homecare agency providers must meet provider qualifications for in-home caregivers in WAC 388-71-0500 through 388-71-0556.

(3) Providers of personal care services for adults must comply with the training requirements in these rules governing medicaid personal care providers in WAC 388-71-05670 through 388-71-05799.

(4) Natural, step, or adoptive parents can be the personal care provider of their adult child age eighteen or older.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1305, filed 9/22/08, effective 10/23/08. Statutory

Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1305, 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 chapter[s] 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 ADSA.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1310, filed 9/22/08, effective 10/23/08; 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.]

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 388-845-1400 What are prevocational services? (1) Prevocational services occur in a segregated setting and are designed to prepare you for gainful employment in an integrated setting through training and skill development.

(2) Prevocational services are available in all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1400, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1400, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1405 Who are the qualified providers of prevocational services? Providers of prevocational services must be a county or an individual or agency contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1405, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1410 Are there limits to the prevocational services I can receive? The following limitations apply to your receipt of prevocational services:

(1) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school, or age twenty-two or older to receive prevocational services.

(2) New referrals for prevocational services require prior approval by the DDD regional administrator and county coordinator or their designees.

(3) Prevocational services are a time limited step on the pathway toward individual employment and are dependent on your demonstrating steady progress toward gainful employment over time. Your annual vocational assessment will include exploration of integrated settings within your next service year. Criteria that would trigger a review of your need for these services include, but are not limited to:

(a) Compensation at more than fifty percent of the prevailing wage;

(b) Significant progress made toward your defined goals;

(c) Your expressed interest in competitive employment; and/or

(d) Recommendation by your individual support plan team.

(4) You will not be authorized to receive prevocational services in addition to community access services or supported employment services.

(5) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

(6) Your service hours are determined by the assistance you need to reach your employment outcomes.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1410, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1410, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1500 What are residential habilitation services? Residential habilitation services (RHS) are available in the CORE and community protection waivers.

(1) Residential habilitation services include assistance:

(a) With personal care and supervision; and

(b) To learn, improve or retain social and adaptive skills necessary for living in the community.

(2) Residential habilitation services may provide instruction and support addressing one or more of the following outcomes:

(a) Health and safety;

(b) Personal power and choice;

(c) Competence and self-reliance;

(d) Positive recognition by self and others;

(e) Positive relationships; and

(f) Integration into the physical and social life of the community.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1500, 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 388-845-1510 Who are qualified providers of residential habilitation services for the community protection waiver? Providers of residential habilitation services for participants of the community protection waiver are limited to state operated living alternatives (SOLA) and supported living providers who are contracted with DDD and certified under chapter 388-101 WAC as a residential community protection provider intensive supported living services (CP-ISLS).

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1510, 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 388-845-1600 What is respite care? Respite care is short-term intermittent relief for persons normally providing care for waiver individuals. This service is available in the Basic, Basic Plus, and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1600, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1600, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1605 Who is eligible to receive respite care? You are eligible to receive respite care if you are in the Basic, Basic Plus or CORE waiver and:

(1) You live in a private home and no one living with you is paid to be your caregiver;

(2) You live with a paid caregiver who is your natural, step or adoptive parent; or

(3) You live with a caregiver who is paid by DDD to provide care to you and is:

(a) A contracted companion home provider; or

(b) A licensed children's foster home provider.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.120, and Title 71A RCW. 08-03-109, § 388-845-1605, filed 1/22/08, effective 2/22/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1605, 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 following 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 your 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 will not be paid to provide DDD services for you or other persons at the same time you receive respite services.

(6) If your personal care provider is your parent, your parent provider will not be paid to provide respite services to any client in the same month that you receive respite services.

(7) DDD cannot pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

(8) 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. 08-20-033, § 388-845-1620, filed 9/22/08, effective 10/23/08; 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 388-845-1650 What are sexual deviancy evaluations? (1) Sexual deviancy evaluations:

(a) Are professional evaluations that assess the person's needs and the person's level of risk of sexual offending or sexual recidivism;

(b) Determine the need for psychological, medical or therapeutic services; and

(c) Provide treatment recommendations to mitigate any assessed risk.

(2) Sexual deviancy evaluations are available in all four waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1650, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1650, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1655 Who is a qualified provider of sexual deviancy evaluations? The provider of sexual deviancy evaluations must:

(1) Be a certified sexual offender treatment provider (SOTP); and

(2) Meet the standards contained in WAC 246-930-030 (education required prior to examination) and WAC 246-930-040 (professional experience required prior to examination).

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-1655, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1655, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1660 Are there limitations to the sexual deviancy evaluations I can receive? (1) Sexual deviancy evaluations must meet the standards contained in WAC 246-930-320.

(2) Sexual deviancy evaluations require prior approval by the DDD regional administrator or designee.

(3) The costs of sexual deviancy 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. 08-20-033, § 388-845-1660, filed 9/22/08, effective 10/23/08; 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 388-845-1700 What is skilled nursing? (1) Skilled nursing is continuous, intermittent, or part time nursing services. These services are available in the Basic Plus, CORE, and community protection waivers.

(2) Services include nurse delegation services provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.

(3) These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1700, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1705 Who is a qualified provider of skilled nursing services? The provider of skilled nursing services must be a licensed practical nurse (LPN) or registered nurse (RN) acting within the scope of the Nurse Practice Act chapter 246-845 WAC and contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1705, 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 388-845-1805 Who are the qualified providers of specialized medical equipment and supplies? The provider of specialized medical equipment and supplies must be a medical equipment supplier contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1805, 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 388-845-1900 What are specialized psychiatric services? (1) Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms. These services are available in all four HCBS waivers.

(2) Service may be any of the following:

(a) Psychiatric evaluation,

(b) Medication evaluation and monitoring,

(c) Psychiatric consultation.

(3) These services are also available as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1905 Who are qualified providers of specialized psychiatric services? Providers of specialized psychiatric services must be one of the following licensed or registered, and contracted healthcare professionals:

(1) Psychiatrist;

(2) Psychiatric advanced registered nurse practitioner (ARNP); or

(3) Physician assistant working under the supervision of a psychiatrist.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1905, 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 388-845-2100 What are supported employment services? Supported employment services provide you with intensive ongoing support if you need individualized assistance to gain and/or maintain employment. These services are tailored to your individual needs, interests, abilities, and promote your career development. These services are provided in individual or group settings and are available in all four HCBS waivers.

(1) Individual supported employment services include activities needed to sustain minimum wage pay or higher. These services are conducted in integrated business environments and include the following:

(a) Creation of work opportunities through job development;

(b) On-the-job training;

(c) Training for your supervisor and/or peer workers to enable them to serve as natural supports to you on the job;

(d) Modification of your work site tasks;

(e) Employment retention and follow along support; and

(f) Development of career and promotional opportunities.

(2) Group supported employment services are a step on your pathway toward gainful employment in an integrated setting and include:

(a) The activities outlined in individual supported employment services;

(b) Daily supervision by a qualified employment provider; and

(c) Groupings of no more than eight workers with disabilities.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-2100, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2105 Who are qualified providers of supported employment services? Supported employment services providers must be a county, or agencies or individuals contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-2105, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2110 Are there limits to the supported employment services I can receive? The following limitations apply to your receipt of supported employment services:

(1) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school, or age twenty-two or older to receive supported employment services.

(2) Payment will be made only for the employment support you require as a result of your disabilities.

(3) Payment for individual supported employment excludes the supervisory activities rendered as a normal part of the business setting.

(4) You will not be authorized to receive supported employment services in addition to community access or prevocational services.

(5) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of supported employment service you may receive.

(6) Your service hours are determined by the assistance you need to reach your employment outcomes and might not equal the number of hours you spend on the job or in job related activities.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-2110, filed 9/22/08, effective 10/23/08. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2110, 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 388-845-2205 Who is qualified to provide transportation services? The provider of transportation services can be an individual or agency contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2205, 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.

(12) If your individual personal care provider uses his/her own vehicle to provide transportation to you for essential shopping and medical appointments as a part of your personal care service, your provider may receive up to sixty miles per month in mileage reimbursement. If you work with more than one individual personal care provider, your limit is still a total of sixty miles per month. This cost is not counted toward the dollar limitation for aggregate services in the Basic or Basic Plus waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 and Title 71A RCW. 08-20-033, § 388-845-2210, filed 9/22/08, effective 10/23/08; 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.]

ASSESSMENT AND INDIVIDUAL SUPPORT PLAN

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 388-845-3015 How is the waiver respite assessment administered? The waiver respite assessment is administered by department staff during an in-person interview with you if you choose to be present, and at least one other person with knowledge of you, such as your primary caregiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3020 Who can be the respondent for the waiver respite assessment? The respondent for your waiver respite assessment must be an adult who is well acquainted with you and can provide the information needed to complete the assessment, such as your primary caregiver.

(1) You cannot be the respondent for your own respite assessment.

(2) The department may select and interview additional respondents as needed to get complete and accurate information.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3020, 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 388-845-3080 What if my needs exceed the maximum yearly funding limit or the scope of services under the Basic or Basic Plus waiver? (1) If you are on the Basic or Basic Plus waiver and your assessed need for services exceeds the maximum permitted, DDD will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available nonwaiver services not included in the Basic or Basic Plus waiver other than natural supports;

(c) Authorize emergency services up to six thousand dollars per year if your needs meet the definition of emergency services in WAC 388-845-0800.

(2) If emergency services and other efforts are not sufficient to meet your needs, you will be offered:

(a) An opportunity to apply for an alternate waiver that has the services you need;

(b) Priority for placement on the alternative waiver when there is capacity to add people to that waiver;

(c) Placement in an ICF/MR.

(3) If none of the options in subsections (1) and (2) above is successful in meeting your health and welfare needs, DDD may terminate your waiver eligibility.

(4) If you are terminated from a waiver, you will remain eligible for nonwaiver DDD services but access to state-only funded DDD services is limited by availability of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3080, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3085 What if my needs exceed what can be provided under the CORE or community protection waiver? (1) If you are on the CORE or community protection waiver and your assessed need for services exceeds the scope of services provided under your waiver, DDD will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available nonwaiver services not included in the CORE or community protection waiver other than natural supports;

(c) Offer you the opportunity to apply for an alternate waiver that has the services you need, subject to WAC 388-845-0045;

(d) Offer you placement in an ICF/MR.

(2) If none of the above options is successful in meeting your health and welfare needs, DDD may terminate your waiver eligibility.

(3) If you are terminated from a waiver, you will remain eligible for nonwaiver DDD services but access to state-only funded DDD services is limited by availability of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3085, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3090 What if my identified health and welfare needs are less than what is provided in my current waiver? If your identified health and welfare needs are less than what is provided in your current waiver, DDD may terminate you from your current waiver and enroll you in a waiver that meets but does not exceed your assessed need for waiver services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3090, 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.]

WAC 388-845-4010 How do I appeal a department action? (1) Your rights to appeal a department decision are in RCW 71A.10.050 and WAC 388-825-120 and are limited to an applicant, recipient, or former recipient of services from the division of developmental disabilities.

(2) If you want to appeal a department action, you must request an appeal within ninety days from receipt of the department notice of the action you are disputing.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4015 Will my services continue during an appeal? Services may continue according to the provisions contained in WAC 388-825-145.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4015, filed 12/13/05, effective 1/13/06.]

Chapter 388-850 WAC

COUNTY PLAN FOR DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-25 WAC)

WAC

WAC 388-850-010 Definitions. (1) All terms used in this chapter not defined herein shall have the same meaning as indicated in the act.

(2) "Act" means local funds for community services chapter 71.20 RCW, State services chapter 71A.12 RCW, and Local services chapter 71A.14 RCW as now existing or hereafter amended.

(3) "County" means each county or two or more counties acting jointly.

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

(5) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(6) "Indian" shall mean any:

(a) Person enrolled in or eligible for enrollment in a recognized Indian tribe; any person determined to be or eligible to be found to be an Indian by the secretary of the interior; and any Eskimo, Aleut or other Alaskan native;

(b) Canadian Indian person who is a member of a treaty tribe, Metis community, or other nonstatus Indian community from Canada;

(c) Unenrolled Indian person considered an Indian by a federally or nonfederally recognized Indian tribe or by an urban Indian/Alaska community organization.

(7) "Plan" means the application a county submits to the secretary for review and approval under the act(s); or revision of an existing plan.

(8) "Population" means the most recent estimate of the aggregate number of persons located in the designated county as computed by the office of financial management.

(9) "Secretary" means the secretary of the department or such employee or such unit of the department as the secretary may designate.

[99-19-104, recodified as § 388-850-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-010, filed 7/8/93, effective 8/8/93. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-010, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-010, filed 1/12/83; Order 1142, § 275-25-010, filed 8/12/76. Formerly chapters 275-12, 275-13 and 275-29 WAC.]

WAC 388-850-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 388-850-010(5) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-015, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-015, filed 8/9/91, effective 9/9/91.]

WAC 388-850-020 Plan development and submission. (1) All dates in this section refer to the twenty-four-month period prior to the start of the state fiscal biennium.

(2) Before July 1, in the odd year of each biennium, the department shall negotiate with and submit to counties the biennial plan guidelines.

(3) Before July 1, the department shall submit to counties needs assessment data, and before December 31, updated needs assessment data in the odd year of each biennium.

(4) Before April 1, of the even year of each biennium, each county shall submit to the department a written plan for developmental disabilities services for the subsequent state fiscal biennium. The county's written plan shall be in the form and manner prescribed by the department in the written guidelines.

(5) Within sixty days of receipt of the county's written plan, the department shall acknowledge receipt, review the plan, and notify the county of errors and omissions in meeting minimum plan requirements.

(6) Within thirty days after receipt, each county shall submit a response to the department's review when errors and omissions have been identified within the review.

(7) Before December 15 of the even year of each biennium, the department shall announce the amount of funds included in the department's biennial budget request to each county. The department shall announce the actual amount of funds appropriated and available to each county as soon as possible after final passage of the Biennial Appropriations Act.

(8) Each county shall submit to the department a contract proposal within sixty days of the announcement by the department of the actual amount of funds appropriated and available.

(9) The department may modify deadlines for submission of county plans and responses to reviews or contract proposals when, in the department's judgment, the modification enables the county to improve the program or planning process.

(10) The department may authorize the county to continue providing services in accordance with the previous plan and contract, and reimburse at the average level of the previous contract, in order to continue services until the new contract is executed.

[99-19-104, recodified as § 388-850-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-25-020, filed 4/21/92, effective 5/21/92. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-020, filed 1/12/83. Statutory Authority: RCW 69.54.040. 78-08-086 (Order 1322), § 275-25-020, filed 7/28/78; Order 1142, § 275-25-020, filed 8/12/76.]

WAC 388-850-025 Program operation—General provisions. (1) The provisions of this section shall apply to all programs operated under authority of the acts.

(2) The county and all contractors and subcontractors must comply with all applicable law or rule governing the department's approval of payment of funds for the programs. Verification may be in the manner and to the extent requested by the secretary.

(3) State funds shall not be paid to a county for costs of services provided by the county or other person or organization who or which was not licensed, certified, and approved as required by law or by rule whether or not the plan was approved by the secretary.

(4) The secretary may impose such reasonable fiscal and program reporting requirements as the secretary deems necessary for effective program management.

(5) **Funding.**

(a) The department and county shall negotiate and execute a contract before the department provides reimbursement for services under contract, except as provided under WAC 388-850-020(10).

(b) Payments to counties shall be made on the basis of vouchers submitted to the department for costs incurred under the contract. The department shall specify the form and content of the vouchers.

(c) The secretary may make advance payments to counties, where such payments would facilitate sound program management. The secretary shall withhold advance payments from counties failing to meet the requirements of WAC 388-850-020 until such requirements are met. Any county failing to meet the requirements of WAC 388-850-020 after advance payments have been made shall repay said advance payment within thirty days of notice by the department that the county is not in compliance.

(d) If the department receives evidence a county or subcontractor performing under the contract is:

(i) Not in compliance with applicable state law or rule; or

(ii) Not in substantial compliance with the contract; or

(iii) Unable or unwilling to provide such records or data as the secretary may require, then the secretary may withhold all or part of subsequent monthly disbursement to the county until such time as satisfactory evidence of corrective action is forthcoming. Such withholding or denial of funds shall be subject to appeal under the Administrative Procedure Act (chapter 34.05 RCW).

(6) **Subcontracting.** A county may subcontract for the performance of any of the services specified in the contract. The county's subcontracts shall include:

(a) A precise and definitive work statement including a description of the services provided;

(b) The subcontractor's specific agreement to abide by the acts and the rules;

(c) Specific authority for the secretary and the state auditor to inspect all records and other material the secretary deems pertinent to the subcontract; and agreements by the subcontractor that such records will be made available for inspection;

(d) Specific authority for the secretary to make periodic inspection of the subcontractor's program or premises in order to evaluate performance under the contract between the department and the county; and

(e) Specific agreement by the subcontractor to provide such program and fiscal data as the secretary may require.

(7) **Records: Maintenance.** Client records shall be maintained for every client for whom services are provided and shall document:

(a) Client demographic data;

(b) Diagnosis or problem statement;

(c) Treatment or service plan; and

(d) Treatment or services provided including medications prescribed.

(8) **Liability.**

(a) The promulgation of these rules or anything contained in these rules shall not be construed as affecting the relative status or civil rights or liabilities between:

(i) The county and community agency; or

(ii) Any other person, partnership, corporation, association, or other organization performing services under a contract or required herein and their employees, persons receiving services, or the public.

(b) The use or implied use herein of the word "duty" or "responsibility" or both shall not import or imply liability other than provided for by the statutes or general laws of the state of Washington, to any person for injuries due to negligence predicated upon failure to perform on the part of an applicant, or a board established under the acts, or an agency, or said agency's employees, or persons performing services on said agency's behalf.

(c) Failure to comply with any compulsory rules shall be cause for the department to refuse to provide the county and community agency funds under the contract.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-025, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-030, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-030, filed 1/12/83; Order 1142, § 275-25-030, filed 8/12/76.]

WAC 388-850-030 Appeal procedure. (1) Any agency making application to participate in a county program operated under authority of the act(s), which is dissatisfied with the disposition of its application, or the community board(s) as defined in the act(s) or the community social services board, which is dissatisfied with any aspect of the plan, may appeal for a hearing before the county governing body. The county governing body shall review the appeal and notify the agency or board of its disposition within thirty days after the appeal has been received.

(2) A county which is dissatisfied with the department's disposition of its plan may request an administrative review.

(3) All requests for administrative reviews shall:

(a) Be made in writing to the appropriate program office within the department;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be resolved by the review;

(d) Be signed by, and include the address of the county or its representative;

(e) Be made within thirty days of notification of the decision which is being appealed.

(4) An administrative review and redetermination shall be provided by the department within thirty days of the submission of the request for review, with written confirmation of the findings and the reasons for the findings to be forwarded to the county as soon as possible.

(5) Any county dissatisfied with the finding of an administrative review or who chooses not to request an administrative review may initiate proceedings pursuant to the Administrative Procedure Act (chapter 34.05 RCW).

[99-19-104, recodified as § 388-850-030, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-040, filed 7/8/93, effective 8/8/93; Order 1142, § 275-25-040, filed 8/12/76.]

WAC 388-850-035 Services—Developmental disabilities. (1) A county may purchase and provide services listed under chapter 71A.14 RCW.

(2) The department shall pay a county for department authorized services provided to an eligible developmentally disabled person.

(3) A county may purchase or provide authorized services. Authorized services may include, but are not limited to:

(a) Early childhood intervention services;

(b) Employment services;

(c) Community access services;

(d) Residential services;

(e) Individual evaluation;

(f) Program evaluation;

(g) County planning and administration; and

(h) Consultation and staff development.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-850-035, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-850-035, filed 12/29/03, effective 1/29/04. 99-19-104, recodified as § 388-850-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-520, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-520, filed 3/1/82. Statutory Authority: RCW 71.20.030, 71.20.050, and 71.20.070. 78-04-002 (Order 1278), § 275-25-520, filed 3/2/78; Order 1142, § 275-25-520, filed 8/12/76.]

WAC 388-850-040 Rights—Health and safety assured. A county, when contracting for specific services, must assure that client rights and client health and safety are protected.

[99-19-104, recodified as § 388-850-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-527, filed 3/1/82.]

WAC 388-850-045 Funding formula—Developmental disabilities. (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior biennium, and subject to the availability of state and federal funds;

(b) The distribution of any additional funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served as follows:

(i) On a basis which takes into consideration minimum grant amounts, requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, and the general population of the county, and special education enrollment as well as the population eligible for county-funded developmental disabilities services;

(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;

(iii) A biennial adjustment shall be made after these factors are considered; and

(iv) Counties not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.

(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;

(d) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director. A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.

(4) The department may withhold five or less percent of allocated funds for new programs, for statewide priority programs, and for emergency needs.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-850-045, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-850-045, filed 12/29/03, effective 1/29/04. 99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040. 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030. 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

WAC 388-850-050 Client rights—Notification of client. (1) All agencies providing services under the act shall post a statement of client rights. Such statement shall inform the client of the client's right to:

(a) Be treated with dignity;

(b) Be protected from invasion of privacy;

(c) Have information about him/her treated confidentially;

(d) Actively participate in the development or modification of his/her treatment program;

(e) Be provided treatment in accordance with accepted quality-of-care standards and which is responsive to his/her best interests and particular needs;

(f) Review his/her treatment records with the therapist at least bimonthly: Provided, That information confidential to other individuals shall not be reviewed by the client;

(g) Be fully informed regarding fees to be charged and methods for payment.

(2) Clients shall be informed of their rights pursuant to WAC 388-865-0515 upon admission to inpatient service.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-050, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-050, filed 9/20/99, effective 9/20/99; Order 1142, § 275-25-755, filed 8/12/76.]

Chapter 388-855 WAC

LIABILITY FOR COSTS OF CARE AND HOSPITALIZATION OF THE MENTALLY ILL

(Formerly chapter 275-16 WAC)

WAC

WAC 388-855-0010 Authority. The following rules regarding hospitalization charges are hereby adopted under the authority of Title 71 RCW.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0010, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-010, filed 3/25/81. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-16-010, filed 2/17/78; Order 1, § 275-16-010, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, and 8/2/67.]

WAC 388-855-0015 Definitions. "Adjusted charges" are those [charges levied upon] [amounts charged to] a patient who is or has been confined to a state hospital for the mentally ill, either by voluntary or involuntary admission, and their estates and responsible relatives, which are less than the actual cost of hospitalization as reflected in the schedule of charges herein and which has been established by the issuance of a notice of finding of responsibility.

"Adjusted gross income" is that gross income of the estate of the patient and responsible relatives less any deductions, contributions or payments mandated by law including, but not necessarily limited to, income tax and social security.

"Dependent" means any spouse, minor son or daughter, or permanently disabled son or daughter, of the patient living in the patient's household. If the patient is a minor, then the same definitions shall apply in determining the dependency of members of the parent's household. If a minor son or daughter is not living in the patient's household, that son or daughter shall not be considered a dependent unless the patient is in fact contributing more than fifty percent of that child's support in accordance with a court order or court-recognized agreement.

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

"Determination officer" is that duly appointed and qualified claims investigator who is delegated authority by the secretary to conduct or cause to have conducted an investigation of the financial condition of the estate of the patient

and responsible relatives; to evaluate the results of such investigations; to make determinations of the ability to pay hospitalization changes from such investigations and evaluations; and to issue notices of findings of responsibility to the responsible parties.

"Estate of patient and responsible relative" means the total assets available to the patient and his responsible relatives to reimburse the department for hospitalization charges incurred by the patient in a state hospital for the mentally ill in accordance with these regulations.

"Gross income" means the total assets available to the estate of the patient and responsible relatives expressed in terms of their cash equivalent on a monthly basis. The total assets available to the estate of the patient and responsible relatives are converted to a monthly cash equivalent figure by dividing those assets by twelve months. Gross income includes all of the following calculated prior to any mandatory deductions; gross wages for service; net earnings from self-employment; and all other assets divided by twelve months.

"Responsible relative" includes the spouse of a patient, or the parent of a patient who is under eighteen years of age.

"Secretary" means the secretary of the department of social and health services.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0015, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-015, filed 3/25/81.]

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 388-855-0030 Schedule of charges. Under RCW 43.20B.325, the department shall base hospitalization charges for patients in state hospitals on the actual operating costs of such hospitals. The department shall require patient's hospitalization charges due and payable on or before the tenth day of each calendar month for services rendered to department patients during the preceding month. A schedule of each hospital's charge rates will be computed under this section based on actual operating costs of the hospital for the previous year. The schedule will be prepared by the secretary's designee, from financial and statistical information contained in hospital records. The schedule will be updated at least annually. All changes under this section shall be prepared in advance of the effective date. Each hospital will make available the schedule of current charge rates upon request.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.325. 94-16-048 (Order 3764), § 275-16-030, filed 7/27/94, effective 8/27/94; 93-22-031 (Order 3659), § 275-16-030, filed 10/27/93, effective 11/27/93; 92-17-007 (Order 3434), § 275-16-030, filed 8/6/92, effective 9/6/92; 92-09-118 (Order 3376), § 275-16-030, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 43.20B.335. 91-21-122 (Order 3267), § 275-16-030, filed 10/23/91, effective 11/23/91; 91-17-064 (Order 3235), § 275-16-030, filed 8/20/91, effective 9/20/91; 91-08-014 (Order 3155), § 275-16-030, filed 3/26/91, effective 4/26/91. Statutory Authority: RCW 43.20B.335 and 71.05.560. 90-18-004 (Order 3061), § 275-16-030, filed 8/23/90, effective 9/23/90. Statutory Authority: RCW 71.02.412. 89-22-128 (Order 2890), § 275-16-030, filed 11/1/89, effective 12/2/89. Statutory Authority: RCW 43.20B.335. 88-21-095 (Order 2715), § 275-16-030, filed 10/19/88. Statutory Authority: RCW 71.02.412. 87-19-026 (Order 2531), § 275-16-030, filed 9/10/87; 86-17-075 (Order 2414), § 275-16-030, filed 8/19/86; 85-17-038 (Order 2273), § 275-16-030, filed 8/15/85; 84-17-011 (Order 2131), § 275-16-030, filed 8/3/84; 83-18-029 (Order 2019), § 275-16-030, filed 8/31/83; 82-17-070 (Order 1866), § 275-16-030, filed 8/18/82; 80-06-087 (Order 1508), § 275-16-030, filed 5/28/80. Statutory Authority: RCW 72.01.090. 79-03-019 (Order 1372), § 275-16-030, filed 2/21/79; 78-03-029 (Order 1270), § 275-16-030, filed 2/17/78; Order 1190, § 275-16-030, filed 2/18/77; Order 1086, § 275-16-030, filed 1/15/76; Order 1002, § 275-16-030, filed 1/14/75; Order 947, § 275-16-030, filed 6/26/74; Order 812, § 275-16-030, filed 6/28/73; Order 14, § 275-16-030, filed 5/11/71; Order 6, § 275-16-030, filed 1/10/69; Order 1, § 275-16-030, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, 8/2/67, and 7/28/67.]

WAC 388-855-0035 Available assets of estate of patients and responsible relatives. (1) The department will include, but not necessarily be limited to, in their determination of the assets of the estates of present and former patients of state hospitals for the mentally ill and their responsible relatives, cash, stocks, bonds, savings, security interests, insurance benefits, guardianship funds, trust funds, governmental benefits, pension benefits and personal property.

(2) Real property shall also be an available asset to the estate: Provided, That the patient's home shall not be considered an available asset if that property is owned by the estate and serves as the principal dwelling and actual residence of the patient, the patient's spouse, and/or minor children and disabled sons or daughters: Provided further, That if the home is not being used for residential purposes by the patient, the patient's spouse, and/or minor children and disabled sons or daughters, and in the opinion of two physicians, there is no reasonable expectancy that the patient will be able to return to the home during the remainder of his life, the home shall be considered an asset available to the estate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0035, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-035, filed 3/25/81.]

WAC 388-855-0045 Exempt income. Patients whose total resources are insufficient to pay for the actual cost of care shall be entitled to a monthly exemption from income in the amount of forty-one dollars and sixty-two cents or such amount as specified in WAC 388-478-0040.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0045, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 388-16-045 (codified as WAC 275-16-045), filed 2/17/78.]

WAC 388-855-0055 Notice and finding of responsibility (NFR)—Appeal procedure. (1) The determination officer's assessment of the ability and liability of a person or of the person's estate to pay hospitalization charges shall be issued in the form of a notice and finding of responsibility (NFR) as prescribed by RCW 43.20B.340.

(2) When the NFR is for full hospitalization charges as specified under WAC 388-855-0030, the department shall:

(a) Inform the financially responsible person of the current charges; and

(b) Periodically recompute the financially responsible person's charges.

(3) When the NFR is for adjusted charges, the department shall:

(a) Express the charges in a daily or monthly rate; and

(b) Set aside charges for ancillary services.

(4) The right to an adjudicative proceeding to contest the NFR is contained in RCW 43.20B.340.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the contested NFR.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.340, this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0055, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-16-055, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.335. 90-04-075 (Order 3001), § 275-16-055, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-055, filed 3/25/81.]

WAC 388-855-0065 Determination of liability. (1) In determining the ability of the estate of the patient and responsible relative to pay hospitalization charges, first priority shall be given to any third party benefits which might be available. The availability of third party benefits, such as medical insurance, health insurance, medicare, medicaid, CHAMPUS, CHAMPVA, shall be considered as an available asset of the estate and shall justify a finding for actual costs of hospitalization during such period as the coverage is in effect.

(2) In the absence of third party benefits, charges shall be based upon the available assets of the estate giving consideration to any unusual and exceptional circumstances and other pertinent factors. No financial determination of the ability of the estate to pay hospitalization charges shall conflict with the eligibility requirements for medicaid for those patients who are eligible or potentially eligible for such benefits.

(3) The ability of the estate to pay adjusted charges will be determined by applying the following formula:

X = (Z-E)F
Where Z = (A-Y-N-R)÷D
Z = available income per family member
X = adjusted charges (daily)
A = gross income
Y = mandatory deductions
N = allowance for unusual and exceptional circumstances
R = allowance for other pertinent factors
D = number of dependents
E = exempt income
F = a factor which converts the monthly figures to a daily rate (.0328767).

All calculations are expressed in monthly terms except the final adjusted charge which is converted to a daily rate. All final figures are rounded out to the nearest cent.

(4) The adjusted gross income (A-Y) is determined by first developing the gross income of the estate of the patient and the responsible relative. Gross income (A) includes not only gross wages for services rendered, and/or net earnings from self-employment, but all other available assets which have been divided by twelve months to convert them to a monthly cash equivalent figure. All mandatory deductions (Y), such as income tax and social security, are deducted from the gross income to arrive at the adjusted gross income.

(5) Approved allowances for unusual and exceptional circumstances (N) and for other pertinent factors (R) are then subtracted from the adjusted gross income.

(6) The available income (A-Y-N-R) is then divided by the number of dependents in the household of the patient (D) to determine the available income per family member.

(7) Exempt income (E) as defined in WAC 388-855-0045 is then subtracted from the available income per family member to arrive at the monthly adjusted charges.

(8) The monthly adjusted charges are multiplied by the factor of .0328767 which converts the monthly figure to a daily rate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0065, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-065, filed 3/25/81.]

WAC 388-855-0075 Unusual and exceptional circumstances. Unusual and exceptional circumstances for these purposes will cover those expenses other than usual or common; rare and extraordinary; that are of a medical nature and *must* be supplied to the patient for his health, medical or physical well being. Such expenses do not include those expenses that are reimbursable from insurance benefits or can be reasonably obtained from welfare agencies, health maintenance organizations, free clinics, or other free private or governmental sources. The existence and necessity of such unusual and exceptional circumstances must be attested to in writing, by the institution superintendent, that those expenses resulting therefrom are an integral part of the patient's treatment plan and that allowance for such circumstances is necessary for the medical and/or mental well-being of the patient. Upon such written certification, the resources necessary to meet the unusual and exceptional circumstances will not be considered as an asset available to the estate of the patient and responsible relatives for these purposes: Provided, That any such attestation by the institution superintendent must conform with the eligibility criteria of medicaid if the patient is eligible or potentially eligible for such benefits.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0075, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-075, filed 3/25/81.]

WAC 388-855-0085 Other pertinent factors. The determination officer may consider the following other pertinent factors in determining the ability of the estate of the patient and responsible relatives to pay.

(1) The determination officer may consider those factors related to the well-being, education and training, child support obligations set by court order or by administrative finding under chapter 74.20A RCW, and/or rehabilitation of the patient and the patient's immediate family, to whom the patient owes a duty of support. The patient and/or responsible relatives shall show the existence and the necessity for the pertinent factors as defined. Upon such a showing, the determination officer may consider such resources necessary to reasonably provide for such pertinent factors as assets not available to the estate of the patient and responsible relatives.

(2) Consistent with RCW 43.20B.335, the determination officer shall consider a judgment owed by the patient to any victim of an act that would have resulted in criminal conviction of the patient but for a finding of the patient's criminal insanity. A victim shall include an estate's personal representative who has obtained judgment for wrongful death against the criminally insane patient.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0085, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 96-18-090, § 275-16-085, filed 9/4/96, effective 10/5/96. 81.02.412 [71.02.412]. Statutory Authority: RCW 81-08-020 (Order 1627), § 275-16-085, filed 3/25/81.]

WAC 388-855-0095 Failure to cooperate with department. Any patient, former patient, guardian, or other responsible party or parties who, after diligent effort by the department, has been shown to have failed to cooperate with the financial investigation by the department; or fails to comply with, or ignores, departmental correspondence; or supplies false or misleading information; or willfully conceals assets or potential assets; will be subject to a determination by the department that the estate of the patient and responsible relatives has the ability to pay full hospitalization charges: Provided, That no person adjudged incompetent by a court of this state at the time of said investigation shall be penalized by his or her actions: Provided further, That such a finding of liability to pay full hospitalization charges shall in no way diminish the responsible party's right to appeal such a finding of responsibility.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0095, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-095, filed 3/25/81.]

WAC 388-855-0105 Petition for review. (1) After a finding of responsibility becomes final in accordance with RCW 43.20B.340, the responsible party may petition for a review of such findings to the secretary. The petitioner must show a substantial change in the financial ability of the estate to pay the charges in a petition for review. The burden of proof of a change in financial ability rests with the petitioner.

(2) A petition for review shall be in writing and to the following address:

Secretary, DSHS
Attn: Determination Officer
P.O. Box 9768 MS HJ-21
Olympia, WA 98504

(3) The determination officer, upon receipt of the petition for review, may conduct or cause to have conducted such investigation as may be necessary to verify the alleged changes in financial status or to determine any other facts which would bear upon the financial ability of the estate to pay.

(4) Based upon the review of the facts, the determination officer may modify or vacate the NFR under the provisions of RCW 43.20B.350.

(5) The NFR will not be modified or vacated, if such modification or vacation inflicts or causes the loss of medicaid eligibility; jeopardizes the eligibility for other third-party benefits; or has the potential end result of diminishing or jeopardizing the recovery of hospitalization cost by the department without a clear showing of real benefit, financial or otherwise, to the patient and/or responsible relatives.

(6) Nothing herein is intended to preclude the reinvestigation and/or review of the finding of responsibility by the department of its own volition.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0105, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335. 90-23-071 (Order 3096), § 275-16-105, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-105, filed 3/25/81.]

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

SECTION ONE—COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

SECTION TWO—REGIONAL SUPPORT NETWORKS

SECTION THREE—MENTAL HEALTH PREPAID HEALTH PLANS

SECTION FOUR—COMMUNITY SUPPORT SERVICE PROVIDERS

SECTION FIVE—INPATIENT EVALUATION AND TREATMENT FACILITIES

SECTION SIX—DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-865-0201 Allocation of funds to RSN/PHPs. [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, § 388-865-0201, filed 5/31/01, effective 7/1/01.] Repealed by 06-18-057, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 71.24.035 and chapter 71.24 RCW.

388-865-0203 Allocation formula for state hospital beds. [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, § 388-865-0203, filed 5/31/01, effective 7/1/01.] Repealed by 06-18-057, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 71.24.035 and chapter 71.24 RCW.

388-865-0340 Consumer disenrollment. [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, § 388-865-0340, filed 5/31/01, effective 7/1/01.] Repealed by 05-17-154, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.24.035.

388-865-0501 Certification based on deemed status. [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, § 388-865-0501, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0502 Single bed certification. [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, § 388-865-0502, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0504 Exception to rule—Long-term certification. [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, § 388-865-0504, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0505 Evaluation and treatment facility certification—Minimum standards. [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, § 388-865-0505, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0510 Standards for administration. [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, § 388-865-0510, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0515 Admission and intake evaluation. [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, § 388-865-0515, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.

388-865-0525 Clinical record. [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, § 388-865-0525, filed 5/31/01,

SECTION ONE—COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC 388-865-0100 Purpose. Chapter 388-865 of the Washington Administrative Code implements chapters 71.05, 71.24, and 71.34 RCW, and the mental health Title XIX Section 1915 (b) medicaid waiver provisions.

[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, § 388-865-0100, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0105 What the mental health division does and how it is organized. (1) The department of social and health services is designated by the legislature as the state mental health authority, and has designated the mental health division to administer the state mental health program.

(2) Local services are administered by regional support networks or by the mental health division.

(3) Telephone numbers for the mental health division or regional support networks are located in the local telephone directory and can also be obtained by calling the mental health division at the telephone number in subsection (4) of this section.

(4) To request an organizational chart, contact the mental health division at 1-888-713-6010 or (360) 902-8070, or write to the Mental Health Division Director, P.O. Box 45320, Olympia, WA 98504.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0105, filed 12/30/08, effective 1/30/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0105, filed 8/18/06, effective 9/18/06. 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, § 388-865-0105, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0106 When local services are administered by the mental health division. (1) The mental health division administers local services if:

(a) A regional support network fails to meet state minimum standards or refuses to exercise responsibilities under RCW 71.24.045; or

(b) The DSHS secretary assumes the duties assigned to a nonparticipating regional support network under RCW 71.24.035(16).

(2) Consumers residing within the boundaries of a nonparticipating regional support network who are eligible for the Title XIX medicaid program are entitled to receive medically necessary services without charge to the consumer;

(3) Within available resources as defined in RCW 71.24.025(2), consumers residing within the boundaries of a nonparticipating regional support network may receive services from any provider of community support services that is contracted with the department under the provisions of chapter 388-502 WAC and licensed by or certified by the mental health division;

(4) When the DSHS secretary assumes the duties assigned to a nonparticipating regional support network, the following standards and services continue to apply:

(a) WAC 388-865-0217 Psychiatric indigent inpatient program;

(b) WAC 388-865-0222 Advisory board;

(c) WAC 388-865-0225 Resource management;

(d) WAC 388-865-0229 Inpatient services;

(e) WAC 388-865-0230 Community support services;

(f) WAC 388-865-0235 Residential and housing services;

(g) WAC 388-865-0240 Consumer employment services;

(h) WAC 388-865-0245 Administration of ITA;

(i) WAC 388-865-0250 Ombuds services;

(j) WAC 388-865-0255 Consumer grievance process; and

(k) WAC 388-865-0284 Standards for contractors and subcontractors.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0106, filed 12/30/08, effective 1/30/09.]

WAC 388-865-0107 Peer counselor certification. The mental health division certifies consumers to provide peer support services.

(1) In order to be certified as a peer counselor, all applicants must meet the following requirements:

(a) Be a self-identified consumer of mental health services, as defined;

(b) Maintain registration as a counselor under chapter 18.19 RCW;

(c) Complete specialized training provided or contracted by the mental health division; and

(d) Successfully pass an examination administered by the mental health division or an authorized contractor.

(2) The training requirement specified in (2)(c) of this subsection is waived for consumers who were trained prior to October 1, 2004 by trainers approved by the mental health division, provided that all of the other requirements are met by January 31, 2005.

(3) A consumer whose request for certification is denied has the right to contest this decision by submitting a written request to the mental health division within twenty-eight calendar days of the date of notification:

(a) The request should include the consumer's name, address, and telephone number and a brief explanation of the issue and resolution being requested;

(b) The consumer also has the right to use the state administrative hearing process as described in chapter 388-02 WAC;

(c) A consumer who completes the administrative hearing process may request reconsideration in accordance with chapter 388-02 WAC but does not have recourse to review by the DSHS board of appeals.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0107, filed 8/22/05, effective 9/22/05.]

WAC 388-865-0110 Access to records of registration. The mental health division, regional support networks, mental health prepaid health plans, and service providers must ensure that information about the fact that a consumer has or is receiving mental health services is not shared or released except as specified under RCW 71.05.390 and other laws and regulations about confidentiality as noted below in WAC 388-865-0115.

[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, § 388-865-0110, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0115 Access to clinical records. There are numerous federal and state rules and regulations on the subjects of confidentiality and access to consumer clinical records. Many of the rules are located in chapter 70.02 RCW, RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.-430, 71.05.440, 71.05.445, 71.05.610 through 71.05.680, 71.34.160, 71.34.162, 71.34.170, 71.34.200, 71.34.210, 71.34.220, 71.34.225, 13.50.100(4)(b), and 42 C.F.R. 431 and 438, and 42 C.F.R. Part 2 of the Code of Federal Regulations and are not repeated in these rules.

[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, § 388-865-0115, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0120 Waiver of a minimum standard of this chapter. (1) A regional support network, mental health prepaid health plan, service provider or applicant subject to the rules in this chapter may request a waiver of any sections or subsections of these rules by submitting a request in writing to the director of the mental health division. The request must include:

(a) The name and address of the entity that is making the request;

(b) The specific section or subsection of these rules for which a waiver is being requested;

(c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the mental health division write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

(2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending mental health division approval of the request, including:

(a) Recommendations, if any, from the quality review team or ombuds staff; and

(b) A description of how consumers will be notified of changes made as a result of the exception.

(3) The mental health division makes a determination on the waiver request within thirty days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal law.

(4) When granting the request, the mental health division issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes:

(a) The section or subsection waived;

(b) The conditions of acceptance;

(c) The time frame for which the waiver is approved;

(d) Notification that the agreement may be reviewed by the mental health division and renewed, if requested.

(5) When denying the request, the mental health division includes the reason for the decision in the notice sent to the person making the request.

(6) The mental health division does not waive any requirement that is part of statute.

[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, § 388-865-0120, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0150 Definitions. "Adult" means a person on or after their eighteenth birthday. For persons eligible for the medicaid program, adult means a person on or after his/her twenty-first birthday.

"Certified peer counselor" is defined as a consumer of mental health services who has met the registration, experience, and training requirements, has satisfactorily passed the

examination, and has been issued a certificate by the mental health division as specified in WAC 388-865-0107.

"Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the medicaid program, child means a person who has not reached his/her twenty-first birthday.

"Clinical services" means those direct age and culturally appropriate consumer services which either:

(1) Assess a consumer's condition, abilities or problems;

(2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

"Consumer" means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

"Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

(1) African American;

(2) An American Indian or Alaskan native, which includes:

(a) A person who is a member or considered to be a member in a federally recognized tribe;

(b) A person determined eligible to be found Indian by the secretary of interior, and

(c) An Eskimo, Aleut, or other Alaskan native.

(d) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or nonstatus Indian community from Canada.

(e) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization.

(3) Asian/Pacific Islander; or

(4) Hispanic.

"Medical necessity" or **"medically necessary" -** A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health division" means the mental health division of the Washington state department of social and health services (DSHS). DSHS has designated the mental health division as the state mental health authority to administer the state and medicaid funded mental health program authorized by chapters 71.05, 71.24, and 71.34 RCW.

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Older person" means an adult who is sixty years of age or older.

"Regional Support Network (RSN)" means a county, a combination of counties, or a private nonprofit entity that administers and provides publicly funded mental health services for a designated geographic area within the state.

"Service recipient" means for the purposes of a mental health prepaid health plan, a consumer eligible for the Title XIX medicaid program.

"Substantial hardship" means that a consumer will not be billed for emergency involuntary treatment if he or she meets the eligibility standards of the psychiatric indigent inpatient program that is administered by the DSHS economic services administration.

"Supervision" means monitoring of the administrative, clinical, or clerical work performance of staff, students, volunteers, or contracted employees by persons with the authority to give direction and require change.

"Underserved" means consumers who are:

(1) Minorities;

(2) Children;

(3) Older adults;

(4) Disabled; or

(5) Low-income persons.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0150, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0150, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.800, and 2003 1st sp.s. c 25. 03-24-030, § 388-865-0150, filed 11/24/03, effective 12/25/03. 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, § 388-865-0150, filed 5/31/01, effective 7/1/01.]

SECTION TWO—REGIONAL SUPPORT NETWORKS

WAC 388-865-0200 Regional support networks. The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section. The community mental health program administered by the regional support network includes the following programs:

(1) Administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapters 71.05 and 71.34 RCW;

(2) Resource management program as defined in RCW 71.24.025(15) and this section;

(3) Community support services as defined in RCW 71.24.025(7);

(4) Residential and housing services as defined in RCW 71.24.025(14);

(5) Ombuds services;

(6) Quality review teams;

(7) Inpatient services as defined in chapters 71.05 and 71.34 RCW; and

(8) Services operated or staffed by consumers, former consumers, family members of consumers, or other advocates. If the service is clinical, the service must comply with the requirements for licensed services. Consumer or advocate run services may include, but are not limited to:

(a) Consumer and/or advocate operated businesses;

(b) Consumer and/or advocate operated and managed clubhouses;

(c) Advocacy and referral services;

(d) Consumer and/or advocate operated household assistance programs;

(e) Self-help and peer support groups;

(f) Ombuds service; and

(g) Other services.

[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, § 388-865-0200, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0205 Initial certification of a regional support network. An entity is initially certified if it is selected to be a regional support network for a designated geographic area through a Request for Proposal process. In order to gain certification as a regional support network under circumstances other than through a Request for Proposal, an entity must submit to the department:

(1) A statement of intent to become a regional support network;

(2) A preliminary operating plan which meets departmental guidelines and complies with the requirements of RCW 71.24.045 and 71.24.300.

(3) If the entity proposes to serve more than one county or the designated geographic area includes a tribal authority, the entity must also include a joint operating agreement that includes the following:

(a) Identification of a single authority with final responsibility for all available resources and performance of the

contract with the department consistent with chapters 71.05, 71.24, and 71.34 RCW;

(b) Assignment of all responsibilities required by RCW 71.24.300; and

(c) Participation of tribal authorities in the agreement at the request of the tribal authorities.

(4) Within thirty days of the submission the department will provide a written response either:

(a) Certifying the regional support network; or

(b) Denying certification because the requirements are not met.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0205, filed 8/18/06, effective 9/18/06. 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, § 388-865-0205, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0210 Renewal of regional support network certification. At least biennially the mental health division reviews the compliance of each regional support network with the statutes, applicable rules and regulations, applicable standards, and state minimum standards as defined in this chapter:

(1) If the regional support network is in compliance with the statutes, applicable rules and regulations, applicable standards, and state minimum standards, the mental health division provides the regional support network with a written certificate of compliance.

(2) If the regional support network is not in compliance with the statutes, applicable rules and regulations, the mental health division will provide the regional support network written notice of the deficiencies. In order to maintain certification, the regional support network must develop a plan of corrective action approved by the mental health division.

(3) If the regional support network fails to develop an approved plan of corrective action or does not complete implementation of the plan within the time frames specified, the mental health division may initiate procedures to suspend, revoke, limit, or restrict certification consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.-205. The mental health division sends a written decision to revoke, suspend, or modify the former certification, with the reasons for the decision and informing the regional support network of its right to an administrative hearing.

(4) The mental health division may suspend or revoke the certification of a regional support network immediately if the mental health division determines that deficiencies imminently jeopardize the health and safety of consumers.

[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, § 388-865-0210, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0215 Consumer eligibility and payment for services. (1) Within available resources as defined in RCW 71.24.025(2), the regional support network must serve consumers in the following order of priority as defined in RCW 71.24.035 (5)(b):

(a) Acutely mentally ill persons;

(b) Chronically mentally ill adults and severely emotionally disturbed children;

(c) Seriously disturbed persons.

(2) Consumers eligible for the Title XIX medicaid program are entitled to receive covered medically necessary services from a mental health prepaid health plan without charge to the consumer;

(3) The consumer or the parent(s) of a child who has not reached their eighteenth birthday, the legal guardian, or the estate of the consumer is responsible for payment for services provided. The consumer may apply to the following entities for payment assistance:

(a) DSHS for medical assistance;

(b) The community support provider for payment responsibility based on a sliding fee scale; or

(c) The regional support network for authorization of payment for involuntary evaluation and treatment services for consumers who would experience a substantial hardship as defined in WAC 388-865-0150.

[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, § 388-865-0215, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0217 Psychiatric indigent inpatient program. (1) The psychiatric indigent inpatient (PII) program is a state funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the regional support network (RSN).

(2) The psychiatric indigent inpatient (PII) program pays only for emergent voluntary inpatient psychiatric care in community hospitals within the state of Washington. Psychiatric indigent inpatient (PII) does not cover ancillary charges for physician, transportation, pharmacy or other costs associated with an inpatient psychiatric hospitalization.

(3) To be eligible for the psychiatric indigent inpatient (PII) program, a client is subject to the following conditions and limitations:

(a) The client must have a voluntary inpatient psychiatric admission authorized by a regional support network (RSN) in the month of application or within the three months immediately preceding the month of application.

(b) Consumers applying for the psychiatric indigent inpatient (PII) program are subject to the income and resource rules for TANF and TANF-related clients in chapters 388-450 and 388-470 WAC.

(c) If a client's income and/or resources exceed the standard for medically needy (MN), as described in WAC 388-478-0070, the client must spend down the excess amount as described in WAC 388-519-0110 for the client to be eligible for the psychiatric indigent inpatient (PII) program. Spenddown is a client financial obligation for medical expenses. The department deducts the spenddown from payments to providers (see WAC 388-502-0100).

(d) A client who is voluntarily admitted must have incurred an emergency medical expense requirement (EMER) of two thousand dollars over a twelve-month period. EMER is a client financial obligation. The department deducts the EMER from payments to providers (see WAC 388-502-0100).

(i) Qualifying emergency medical expense requirement (EMER) expenses are psychiatric inpatient services in a community hospital.

(ii) The emergency medical expense requirement (EMER) period lasts for twelve calendar months, beginning

on the first day of the month of certification for psychiatric indigent inpatient (PII) and continuing through the last day of the twelfth month.

(e) A client is limited to a single three-month period of psychiatric indigent inpatient (PII) eligibility per twelve-month emergency medical expense requirement (EMER) period.

(4) Clients are not eligible for the psychiatric indigent inpatient (PII) program if they:

(a) Are eligible for, or receiving, any other cash or medical program; or

(b) Entered Washington state specifically to obtain medical care; or

(c) Are inmates of a federal or state prison; or

(d) Are committed under the Involuntary Treatment Act (ITA).

[Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-865-0217, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.800, and 2003 1st sp.s. c 25. 03-24-030, § 388-865-0217, filed 11/24/03, effective 12/25/03.]

WAC 388-865-0220 Standards for administration. The regional support network must demonstrate that it meets the requirements of chapters 71.05, 71.24, and 71.34 RCW, and ensures the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner. The regional support network must:

(1) Establish a governing board that includes, where applicable, representation from tribal authorities, consistent with RCW 71.24.300;

(2) For multicounty regional support networks, function as described in the regional support network joint operating agreement;

(3) Ensure the protection of consumer and family rights as described in this chapter, and chapters 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems;

(4) Collaborate with and make reasonable efforts to obtain and use resources in the community to maximize services to consumers;

(5) Educate the community regarding mental illness to diminish stigma;

(6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to ensure that persons eligible for regional support network services have access to inpatient care;

(7) Develop publicized forums in which to seek and include input about service needs and priorities from community stakeholders, including:

(a) Consumers;

(b) Family members and consumer advocates;

(c) Culturally diverse communities including consumers who have limited English proficiency;

(d) Service providers;

(e) Social service agencies;

(f) Organizations representing persons with a disability;

(g) Tribal authorities; and

(h) Underserved groups.

(8) Maintain job descriptions for regional support staff with qualifications for each position with the education, experience, or skills relevant to job requirements; and

(9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

(10) Identify trends and address service gaps;

(11) The regional support network must provide an updated two-year plan biennially to the mental health division for approval consistent with the provisions of RCW 71.24.300(1). The biennial plan must be submitted to the regional support network governing board for approval and to the advisory board for review and comment.

[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, § 388-865-0220, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0221 Public awareness of mental health services. The regional support network or its designee must provide public information on the availability of mental health services. The regional support network must:

(1) Maintain listings of services in telephone directories and other public places such as libraries, community services offices, juvenile justice facilities, of the service area. The regional support network or its designee must prominently display listings for crisis services in telephone directories;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited English proficient, or unable to read;

(3) Post and make information available to consumers regarding the ombuds service consistent with WAC 388-865-0250, and local advocacy organizations that may assist consumers in understanding their rights.

[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, § 388-865-0221, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0222 Advisory board. The regional support network must promote active engagement with persons with mental disorders, their families and services providers by soliciting and using their input to improve its services. The regional support network must appoint an advisory board that:

(1) Is broadly representative of the demographic character of the region and the ethnicity and broader cultural aspects of consumers served;

(2) Is composed of at least fifty-one percent:

(a) Current consumers or past consumers of public mental health services, including those who are youths, older adults, or who have a disability; and

(b) Family, foster family members, or care givers of consumers, including parents of emotionally disturbed children.

(3) Independently reviews and provides comments to the regional support network governing board on plans, budgets, and policies developed by the regional support network to implement the requirements of this section, chapters 71.05,

71.24, 71.34 RCW and applicable federal law and regulations.

[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, § 388-865-0222, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0225 Resource management. The regional support network must establish mechanisms which maximize access to and use of age and culturally competent mental health services, and ensure eligible consumers receive appropriate levels of care. The regional support network must:

(1) Authorize admission, transfers and discharges for eligible consumers into and out of the following services:

(a) Community support services;

(b) Residential services; and

(c) Inpatient evaluation and treatment services.

(2) Ensure that services are provided according to the consumer's individualized service plan;

(3) Not require preauthorization of emergency services and transportation for emergency services that are required by an eligible consumer;

(4) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

[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, § 388-865-0225, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0229 Inpatient services. The regional support network must develop and implement age and culturally competent services that are consistent with chapters 71.24, 71.05, and 71.34 RCW. The regional support network must:

(1) For voluntary inpatient services: Develop and implement formal agreements with inpatient services funded by the regional support network regarding:

(a) Referrals;

(b) Admissions; and

(c) Discharges.

(2) For involuntary evaluation and treatment services:

(a) Maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements must address regional support network responsibility for discharge planning;

(b) Determine which service providers on whose behalf the regional support network will apply on behalf of for certification by the mental health division;

(c) Ensure that all service providers or its subcontractors that provide evaluation and treatment services are currently certified by the mental health division and licensed by the department of health;

(d) Ensure periodic reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.

(3) Authorize admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:

(a) State psychiatric hospitals:

(i) Western state hospital;

(ii) Eastern state hospital;

(iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

(4) Receive prior approval from the mental health division in the form of a single bed certification for services to be provided to consumers on a ninety- or one hundred eighty-day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0502; and

(5) Identify in the agreement with the mental health division any of these duties is has delegated to a subcontractor.

[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, § 388-865-0229, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0230 Community support services. The regional support network must develop and coordinate age and culturally competent community support services that are consistent with chapters 71.24, 71.05, and 71.34 RCW:

(1) Provide the following services directly, or contract with sufficient numbers and variety of licensed and/or certified service providers to ensure that persons eligible for regional support network services have access to at least the following services:

(a) Emergency crisis intervention services;

(b) Case management services;

(c) Psychiatric treatment including medication supervision;

(d) Counseling and psychotherapy services;

(e) Day treatment services as defined in RCW 71.24.300 (5) and 71.24.035(7);

(f) Consumer employment services as defined in RCW 71.24.035 (5)(e); and

(g) Peer support services.

(2) Conduct prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9)); and

(3) Complete screening for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9)).

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0230, filed 8/22/05, effective 9/22/05. 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, § 388-865-0230, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0235 Residential and housing services. The regional support network must ensure:

(1) Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.

(2) Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent

risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.

(3) The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24.025 (7) and (14); and 71.24.025(14).

(4) That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (chapter 70.129 RCW).

(5) If supervised residential services are needed they are provided only in licensed facilities:

(a) An adult family home that is licensed under chapter 388-76 WAC.

(b) A boarding home facility that is licensed under chapter 388-78A WAC.

(c) An adult residential rehabilitative center facility that is licensed under chapter 246-325 WAC.

(6) The active search of comprehensive resources to meet the housing needs of consumers.

[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, § 388-865-0235, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0240 Consumer employment services. The regional support network must coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services consistent with WAC 388-865-0464.

[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, § 388-865-0240, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0245 Administration of the Involuntary Treatment Act. The regional support network must establish policies and procedures for administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapters 71.05 and 71.34 RCW. This includes:

(1) Designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of chapters 71.05 and 71.34 RCW.

(2) Documenting consumer compliance with the conditions of less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety and one hundred eighty-day commitments.

(b) Notifying the designated mental health professional if noncompliance with the less restrictive order impairs the individual sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that when a peace officer or designated mental health professional escorts a consumer to a facility, the designated mental health professional must take reasonable precautions to safeguard the consumer's property including:

(a) Safeguarding the consumer's property in the immediate vicinity of the point of apprehension;

(b) Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings;

(c) Taking reasonable precautions to lock and otherwise secure the consumer's home or other property as soon as possible after the consumer's initial detention.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0245, filed 8/18/06, effective 9/18/06. 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, § 388-865-0245, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0250 Ombuds services. The regional support network must provide unencumbered access to and maintain the independence of the ombuds service as set forth in this section and in the agreement between mental health division and the regional support network. The mental health division and the regional support network must include representatives of consumer and family advocate organizations when revising the terms of the agreement regarding the requirements of this section. Ombuds members must be current consumers of the mental health system, past consumers or family members. The regional support network must maintain an ombuds service that:

(1) Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level;

(2) Is independent of service providers;

(3) Receives and investigates consumer, family member, and other interested party complaints and grievances;

(4) Is accessible to consumers, including a toll-free, independent phone line for access;

(5) Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances;

(6) Receives training and adheres to confidentiality consistent with this chapter and chapters 71.05, 71.24, and 70.02 RCW;

(7) Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes;

(8) Involves other persons, at the consumer's request;

(9) Assists consumers in the pursuit of formal resolution of complaints;

(10) If necessary, continues to assist the consumer through the fair hearing processes;

(11) Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients;

(12) Provides information on grievance experience to the regional support network and mental health division quality management process; and

(13) Provides reports and formalized recommendations at least biennially to the mental health division and regional support network advisory and governing boards, quality

review team, local consumer and family advocacy groups, and provider network.

[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, § 388-865-0250, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0255 Consumer grievance process. The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must:

(1) Be age, culturally and linguistically competent;

(2) Ensure acknowledgment of receipt of the grievance the following working day. This acknowledgment may be by telephone, with written acknowledgment mailed within five working days;

(3) Ensure that grievances are investigated and resolved within thirty days. This time frame can be extended by mutual written agreement, not to exceed ninety days;

(4) Be published and made available to all current or potential users of publicly funded mental health services and advocates in language that is clear and understandable to the individual;

(5) Encourage resolution of complaints at the lowest level possible;

(6) Include a formal process for dispute resolution;

(7) Include referral of the consumer to the ombuds service for assistance at all levels of the grievance and fair hearing processes;

(8) Allow the participation of other people, at the grievant's choice;

(9) Ensure that the consumer is mailed a written response within thirty days from the date a written grievance is received by the regional support network;

(10) Ensure that grievances are resolved even if the consumer is no longer receiving services;

(11) Continue to provide mental health services to the grievant during the grievance and fair hearing process;

(12) Ensure that full records of all grievances are kept for five years after the completion of the grievance process in confidential files separate from the grievant's clinical record. These records must not be disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if a fair hearing is requested;

(13) Provide for follow-up by the regional support network to assure that there is no retaliation against consumers who have filed a grievance;

(14) Make information about grievances available to the regional support network;

(15) Inform consumers of their right to file an administrative hearing with DSHS without first accessing the contractor's grievance process. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;

(16) Inform consumers of their right to use the DSHS prehearing and administrative hearing processes as described in chapter 388-02 WAC. Consumers have this right when:

(a) The consumer believes there has been a violation of DSHS rule;

(b) The regional support network did not provide a written response within thirty days from the date a written request was received;

(c) The regional support network, mental health prepaid health plan, the department of social and health services, or a provider denies services.

[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, § 388-865-0255, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0260 Mental health professionals and specialists. The regional support network must assure sufficient numbers of mental health professionals and specialists are available in the service area to meet the needs of eligible consumers. The regional support network must:

(1) Document efforts to acquire the services of the required mental health professionals and specialists;

(2) Ensure development of a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer population;

(3) If more than five hundred persons in the total population in the regional support network geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the regional support network must contract or otherwise establish a working relationship with the required specialists to:

(a) Provide all or part of the treatment services for these populations; or

(b) Supervise or provide consultation to staff members providing treatment services to these populations.

[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, § 388-865-0260, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0265 Mental health professional—Exception. The regional support network may request an exception of the requirements of a mental health professional for a person with less than a masters degree level of training. The mental health division may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions:

(1) The regional support network has made a written request for an exception including:

(a) Demonstration of the need for an exception;

(b) The name of the person for whom an exception is being requested;

(c) The functions which the person will be performing;

(d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:

(i) Bachelor of Arts or Sciences degree from an accredited college or university;

(ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and

(iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional.

(2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted;

(3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception;

(4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the mental health division.

[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, § 388-865-0265, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0270 Financial management. The regional support network must be able to demonstrate that it ensures the effectiveness and cost effectiveness of community mental health services. The regional support network must:

(1) Spend funds received by the mental health division in accordance with its contract and to meet the requirements of chapters 71.05, 71.24, 71.34 RCW, and the State Appropriations Act;

(2) Use accounting procedures that are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP), with the following additional requirements:

(a) Include as assets all property, equipment, vehicles, buildings, capital reserve funds, operating reserve funds, risk reserve funds, or self-insurance funds.

(b) Interest accrued on funds stated in this section must be accounted for and kept for use by the regional support network.

(c) Property, equipment, vehicles, and buildings must be properly inventoried with a physical inventory conducted at least every two years.

(d) Proceeds from the disposal of any assets must be retained by the regional support network for purposes of subsection (1) of this section.

(3) Comply with the 1974 county maintenance of effort requirement for administration of the Involuntary Treatment Act (chapter 71.05 RCW) and 1990 county maintenance of effort requirement for community programs for adults consistent with RCW 71.24.160, and in the case of children, no state funds shall replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985 (chapter 71.34 RCW);

(4) Maintain accounting procedures to ensure that accrued interest and excess reserve balances are returned to the regional support network for use in the public mental health system.

[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, § 388-865-0270, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0275 Management information system. The regional support network must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services. The regional support network must:

(1) Operate an information system and ensure that information about consumers who receive publicly funded mental health services is reported to the state mental health information system according to mental health division guidelines.

(2) Ensure that the information reported is:

(a) Sufficient to produce accurate regional support network reports; and

(b) Adequate to locate case managers in the event that a consumer requires treatment by a service provider that would not normally have access to treatment information about the consumer.

(3) Ensure that information about consumers is shared or released between service providers only in compliance with state statutes (see chapters 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized crisis plans must be available:

(a) Twenty-four hours a day, seven days a week to designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(b) To the state and regional support network staff as required for management information and program review.

(4) Maintain on file a statement signed by regional support network, county or service provider staff having access to the mental health information systems acknowledging that they understand the rules on confidentiality and will follow the rules.

(5) Take appropriate action if a subcontractor or regional support network employee willfully releases confidential information, as required by chapter 71.05 RCW.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0275, filed 8/18/06, effective 9/18/06. 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, § 388-865-0275, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0280 Quality management process. The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The plan must include:

(1) Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support network governing board, clinical and management staff, advisory board, ombuds service, and quality review teams.

(2) Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

(a) Collect, analyze and display information regarding:

(i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements;

(ii) System performance indicators;

(iii) Quality and intensity of services;

(iv) Incorporation of feedback from consumers, allied service systems, community providers, ombuds and quality review team;

(v) Clinical care and service utilization including consumer outcome measures; and

(vi) Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners.

(b) Monitor management information system data integrity;

(c) Monitor complaints, grievances and adverse incidents for adults and children;

(d) Monitor contracts with contractors and to notify the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements;

(e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the mental health division;

(f) Monitor delegated administrative activities;

(g) Identify necessary improvements;

(h) Interpret and communicate practice guidelines to practitioners;

(i) Implement change;

(j) Evaluate and report results;

(k) Demonstrate use of all corrective actions to improve the system;

(l) Consider system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews;

(m) Review update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

(a) Performance measures that are objective, measurable, and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support network;

(b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;

(c) Efficient use of human resources; and

(d) Efficient business practices.

[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, § 388-865-0280, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0282 Quality review teams. The regional support network must establish and maintain unencumbered access to and maintain the independence of a quality review team as set forth in this section and in the agreement between mental health division and the regional support network. The quality review team must include current consumers of the mental health system, past consumers or family members. The regional support network must assure that quality review teams:

(1) Fairly and independently review the performance of the regional support network and service providers to evaluate systemic customer service issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:

(a) Quality of care;

(b) The degree to which services are consumer-focused/directed and are age and culturally competent;

(c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

(d) The adequacy of the regional support network's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any agency providing services for area regional support network consumers, including state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers;

(3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the regional support network to:

(a) Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol developed by the mental health division. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and

(b) Work with interested consumers, service providers, the regional support network, and DSHS to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the mental health division, the mental health advisory committee and the regional support network advisory and governing boards and ensure that input from the quality review team is integrated into the overall regional support network quality management process, ombuds services, local consumer and family advocacy groups, and provider network; and

(5) Receive training and adhere to confidentiality standards.

[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, § 388-865-0282, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0284 Standards for contractors and subcontractors. The regional support network must not subcontract for clinical services to be provided using state funds unless the subcontractor is licensed and/or certified by the mental health division for those services or is personally licensed by the department of health as defined in chapter 48.43, 18.57, 18.71, 18.83, or 18.79 RCW. The regional support network must:

(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state or federal laws;

(2) Follow applicable requirements of the regional support network agreement with the mental health division;

(3) Demonstrate that it monitors contracts with contractors and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract with a provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.

[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, § 388-865-0284, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0286 Coordination with a mental health prepaid health plan. If the regional support network is not also a mental health prepaid health plan, the regional support network must ensure continuity of services between itself and the mental health prepaid health plan by maintaining a working agreement about coordination for at least the following services:

(1) Community support services;

(2) Inpatient evaluation and treatment services;

(3) Residential services;

(4) Transportation services;

(5) Consumer employment services;

(6) Administration of involuntary treatment investigation and detention services; and

(7) Immediate crisis response after presidential declaration of a disaster.

[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, § 388-865-0286, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0288 Regional support networks as a service provider. A regional support network may operate as a community support service provider under the following circumstances:

(1) Meeting the criteria specified in RCW 71.24.037 and 71.24.045;

(2) Maintaining a current license as a community support service provider from the mental health division.

[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, § 388-865-0288, filed 5/31/01, effective 7/1/01.]

SECTION THREE—MENTAL HEALTH PREPAID HEALTH PLANS

WAC 388-865-0300 Mental health prepaid health plans. A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental health services for people who are eligible for the Title XIX medicaid program. The mental health prepaid health plan must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To be eligible for a contract as a mental health prepaid health plan, the entity must:

(1) Provide documentation of a population base of forty-one thousand six hundred medicaid eligible persons (covered lives) within the service area or receive approval from the mental health division based on submittal of an actuarially sound risk management profile;

(2) Maintain certification as a regional support network or licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter 48.44 RCW.

[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, § 388-865-0300, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan. A regional support network contracting with the mental health division as a mental health prepaid health plan must comply with all requirements for a regional support network and the additional requirements for a prepaid health plan.

[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, § 388-865-0305, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0310 Mental health prepaid health plans—Minimum standards. To be eligible for a contract, a mental health prepaid health plan must comply with all applicable federal, state, and local statutes and regulations and meet all of the minimum standards of WAC 388-865-300 through 388-865-355. The mental health prepaid health plan must:

(1) Provide medically necessary mental health services that are age and culturally competent for all medicaid recipients in the service area within a capitated rate;

(2) Provide outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals;

(3) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;

(4) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the mental health prepaid health plan, as identified in the agreement with the mental health division;

(5) Retain responsibility to ensure that applicable standards of state and federal statute and regulations and this chapter are met even when it delegates duties to subcontractors;

(6) Ensure the protection of consumer and family rights as described in chapters 71.05 and 71.34 RCW;

(7) Ensure compliance with the following standards:

(a) WAC 388-865-0220, Standards for administration;

(b) WAC 388-865-0225, Resource management program;

(c) WAC 388-865-0229, Inpatient services and treatment services;

(d) WAC 388-865-0230, Community support services;

(e) WAC 388-865-0250, Ombuds services;

(f) WAC 388-865-0255, Consumer grievance process;

(g) WAC 388-865-0260, Mental health professionals or specialists;

(h) WAC 388-865-0265, Mental health professional—Exception;

(i) WAC 388-865-0270, Financial management;

(j) WAC 388-865-0275, Management information system;

(k) WAC 388-865-0280, Quality management process;

(l) WAC 388-865-0282, Quality review teams; and

(m) WAC 388-865-0284, Standards for contractors and subcontractors.

[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, § 388-865-0310, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0315 Governing body. The mental health prepaid health plan must establish a governing body responsible for oversight of the mental health prepaid health plan. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and fiduciary interests of a governing body member and the best interests of the prepaid health plan and the consumers it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the body scan assign the matter to others, such as staff or advisory bodies.

[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, § 388-865-0315, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0320 Utilization management. Utilization management is the way the mental health prepaid health plan authorizes or denies mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on enrollee access to care of adequate quality, a mental health prepaid health plan must provide utilization management of the community mental health rehabilitation services (42 C.F.R. 440) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled consumers without a wait list consistent with the agreement with the mental health division;

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled consumers;

(6) Develop, implement, and enforce written level of care guidelines for admission, placements, transfers and discharges into and out of services. The guidelines must address:

(a) A clear process for the mental health prepaid health plan's role in the decision-making process about admission and continuing stay at various levels is available in language that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs for all medicaid consumers served, including consumers of different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) To the extent authorization of care at any level of care or at continuing stay determinations is delegated, the mental health prepaid health plan retains a sufficiently strong and regular oversight role to assure those decisions are being made appropriately.

(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs;

(8) Report to the mental health division any knowledge it gains that the mental health prepaid health plan or service provider is not in compliance with all state and federal laws and regulations.

[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, § 388-865-0320, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0325 Risk management. The mental health prepaid health plan must:

(1) Assume the financial risk of providing community mental health outpatient rehabilitation services, community hospital services and operation of a capitated mental health managed care system for the medicaid eligible persons in the service area;

(2) Maintain a risk reserve of annual premium payments as defined by chapter 48.44 RCW or the actuarial analysis submitted with the formal request for waiver for mental health approved by the Health Care Financing Administration. All other mental health reserves and undesignated fund balances shall be limited to no more than ten percent of annual revenues supporting the prepaid health plan's mental health program;

(3) Demonstrate solvency and manage all fiscal matters within the managed care system, including:

(a) Current pro forma;

(b) Financial reports;

(c) Balance sheets;

(d) Revenue and expenditure; and

(e) An analysis of reserve account(s) and fund balance(s) information including a detailed composition of capital, operating, and risk reserves and or fund balances.

(4) Maintain policies for each reserve account and have a process for collecting and disbursing reserves to pay for costs incurred by the mental health prepaid health plan;

(5) Demonstrate capacity to process claims for members of the contracted provider network and any emergency service providers accessed by consumers while out of the mental health prepaid health plan service area within sixty days using methods consistent with generally accepted accounting practices;

(6) Comply with the requirements of section 1128 (b) of the Social Security Act, which prohibits making payments

directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to consumers;

(7) In accordance with the medicaid section 1915b waiver, the mental health prepaid health plan is required to pay for psychiatric inpatient services in community hospitals either through a direct contract with community hospitals or through an agreement with the department. In the event that the mental health prepaid health plan chooses to use the department as its fiscal agent, the plan agrees to abide by all policies, rules, payment requirements, and levels promulgated by the medical assistance administration. If the plan chooses to direct contract, the plan is responsible for executing contracts for sufficient hospital capacity pursuant to a plan approved by the mental health division.

[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, § 388-865-0325, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0330 Marketing/education of mental health services. The mental health prepaid health plan must demonstrate that it provides information to eligible persons so that they are aware of available mental health services and how to access them. The mental health prepaid health plan must:

(1) Develop and submit marketing/education plan(s) and procedures to the mental health division within the time frames in the agreement with the mental health division for approval prior to issuance. The plan shall, at a minimum, include information on the following:

(a) Consumer rights and responsibilities;

(b) The service recipient's right to disenroll;

(c) Cross-system linkages;

(d) Access to mental health services for diverse populations, including other languages than English;

(e) Use of media;

(f) Stigma reduction;

(g) Subcontractor participation/involvement;

(h) Plan for evaluation of marketing strategy;

(i) Procedures and materials, and any revisions thereof; and

(j) Maintain listings of mental health services with toll-free numbers in the telephone and other public directories of the service area.

(2) Describe services and hours of operations through brochures and other materials and other methods of advertising;

(3) Assure that the materials and methods are effective in reaching people who may be visually impaired, have limited comprehension of written or spoken English, or who are unable to read. At a minimum, all written materials generally available to service recipients shall be translated to the most commonly used languages in the service area;

(4) Post and otherwise make information available to consumers about ombuds services and local advocacy organizations that may assist consumers in understanding their rights;

(5) Ensure distribution of written educational material(s) to consumers, allied systems and local community resources including:

(a) Annual brochure(s) containing educational material on major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference of the service recipient;

(b) Information regarding the scope of available benefits (e.g., inpatient, outpatient, residential, employment, community support);

(c) Service locations, crisis response services; and

(d) Service recipients' responsibilities with respect to out-of-area emergency services; unauthorized care; noncovered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.

(6) Ensure marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud the service recipient.

[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, § 388-865-0330, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0335 Consumer enrollment. (1) DSHS enrolls a medicaid recipient in a mental health prepaid inpatient health plan when the person resides in the contracted service area of the prepaid inpatient health plan. The assigned prepaid inpatient health plan is responsible to provide outpatient medically necessary state medicaid plan approved services to medicaid service recipients in the contracted service area and to assure inpatient medically necessary state medicaid plan approved services are received;

(2) An enrolled medicaid service recipient who requests or receives medically necessary nonemergency community mental health rehabilitation services may request and receive such service from the assigned mental health prepaid inpatient health plan through authorized providers only;

(3) An enrolled medicaid service recipient is automatically transferred from the assigned prepaid inpatient health plan when the recipient moves from the contracted service area of one mental health prepaid inpatient health plan to the contracted service area of another;

(4) Services to medicaid recipients may be provided through alternative means if currently contracted authorized providers are not able to provide those services when:

(a) The services are state medicaid plan approved services and are medically necessary for the medicaid service recipient; and

(b) Services are or should be available to other medicaid service recipients in the local mental health prepaid inpatient health plan; and

(c) The medicaid service recipient has made reasonable attempts to utilize services through authorized providers; or

(d) The medicaid service recipient has received a choice of providers and has made an informed decision to request medically necessary services through a provider outside the prepaid inpatient health plan provider network that has cultural or linguistic expertise or both needed to meet medical necessity that are not sufficient within the provider network; or

(e) The medicaid service recipient has utilized the prepaid inpatient health plan grievance or appeal process and the state administrative hearing process, and a decision has been

made in favor of the medicaid service recipient that medicaid plan approved services continue to be medically necessary.

[Statutory Authority: RCW 71.24.035. 05-17-154, § 388-865-0335, filed 8/22/05, effective 9/22/05. 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, § 388-865-0335, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0345 Choice of primary care provider. The mental health prepaid health plan must ensure that each consumer who is receiving nonemergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

(1) For an enrolled client with an assigned case manager, the case manager is the primary care provider;

(2) If the consumer does not make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen working days after the consumer requests services;

(3) The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;

(4) Any additional change of primary care provider during the twelve-month period may be made with documented justification at the consumer's request by:

(a) Notifying the mental health prepaid health plan (or its designee) of his/her request for a change, and the name of the new primary care provider; and

(b) Identifying the reason for the desired change.

(5) A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.

[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, § 388-865-0345, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0350 Mental health screening for children. The mental health prepaid health plan is responsible for conducting mental health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program as specified in contract with the mental health division;

(2) Developing and maintaining an oversight committee for the coordination of the early and periodic screening, diagnosis and treatment program. The oversight committee must include representation from parents of medicaid-eligible children.

[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, § 388-865-0350, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0355 Consumer request for a second opinion. An enrolled consumer in a mental health prepaid health plan must have the right to a second opinion by another participating staff in the enrolled consumer's assigned mental health prepaid health plan:

(1) When the enrolled consumer needs more information about the medical necessity of the treatment recommended by the mental health prepaid health plan; or

(2) If the enrolled consumer believes the mental health prepaid health plan primary care provider is not authorizing medically necessary community mental health rehabilitation services.

[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, § 388-865-0355, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0360 Monitoring of mental health prepaid health plans. The mental health division will conduct an annual on-site medical audit and an administrative audit at least every two years for purposes of assessing the quality of care and conformance with the minimum standards of this section and the Title XIX medicaid 1915(b) mental health waiver requirements. The monitoring will include a review of:

(1) The mental health prepaid health plan's conformance to monitoring its service provider network in accordance with the quality management plan approved by the mental health division that includes processes established under the medicaid waiver for mental health services;

(2) Any direct services provided by the mental health prepaid health plan;

(3) Other provisions within the code of federal regulations for managed care entities, which may include access, quality of care, marketing, record keeping, utilization management and disenrollment functions.

[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, § 388-865-0360, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0363 Coordination with the regional support network. If the mental health prepaid health plan is not also a regional support network, the mental health prepaid health plan must ensure continuity of services between itself and the regional support network by maintaining a working agreement about coordination for at least the following services:

(1) Residential services;

(2) Transportation services;

(3) Consumer employment services;

(4) Administration of involuntary treatment investigation and detention services; and

(5) Immediate crisis response after presidential declaration of a disaster.

[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, § 388-865-0363, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract. The mental health division may suspend, revoke, limit or restrict a mental health prepaid health plan contract or refuse to grant a contract for failure to

conform to applicable state and federal rules and regulations or for violation of health or safety considerations.

[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, § 388-865-0365, filed 5/31/01, effective 7/1/01.]

SECTION FOUR—COMMUNITY SUPPORT SERVICE PROVIDERS

WAC 388-865-0400 Community support service providers. The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 [388-865-0400] through 388-865-450 [388-865-0450] as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought:

(1) Emergency crisis intervention services;

(2) Case management services;

(3) Psychiatric treatment, including medication supervision;

(4) Counseling and psychotherapy services;

(5) Day treatment services;

(6) Consumer employment services; and/or

(7) Peer support services.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0400, filed 8/22/05, effective 9/22/05. 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, § 388-865-0400, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0405 Competency requirements for staff. The licensed service provider must ensure that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements. The provider must maintain documentation that:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for their position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional;

(4) Staff performing mental health services (not including crisis telephone) must have access to consultation with a psychiatrist or a physician with at least one year's experience in the direct treatment of persons who have a mental or emotional disorder;

(5) Mental health services to children, older adults, ethnic minorities or persons with disabilities must be provided by, under the supervision of, or with consultation from the appropriate mental health specialist(s) when the consumer:

(a) Is a child as defined in WAC 866-865-0150 [388-865-0150];

(b) Is or becomes an older person as defined in WAC 388-865-0150;

(c) Is a member of a racial/ethnic group as defined in WAC 866-865-0105 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(d) Is disabled as defined in WAC 388-865-0150 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(6) Staff receive regular supervision and an annual performance evaluation; and

(7) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population served.

[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, § 388-865-0405, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0410 Consumer rights. (1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WAC 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

(a) Be treated with respect, dignity and privacy;

(b) Develop a plan of care and services which meets your unique needs;

(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;

(d) Refuse any proposed treatment, consistent with the requirements in chapters 71.05 and 71.34 RCW;

(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(f) Be free of any sexual exploitation or harassment;

(g) Review your clinical record and be given an opportunity to make amendments or corrections;

(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;

(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are medicaid eligible, receive all services which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from:

(i) A provider within the regional support network about what services are medically necessary; or

(ii) For consumers not enrolled in a prepaid health plan, a provider under contract with the mental health division.

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is:_____;

(o) Ask for an administrative hearing if you believe that any rule in this chapter was incorrectly applied in your case."

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0410, filed 12/30/08, effective 1/30/09. 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, § 388-865-0410, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0415 Access to services. The community support service provider must document and otherwise ensure that eligible consumers have access to age and culturally competent services when and where those services are needed. The provider must:

(1) Identify and reduce barriers to people getting the services where and when they need them;

(2) Comply with the Americans with Disabilities Act and the Washington State Antidiscrimination Act, chapter 49.60 RCW;

(3) Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer;

(4) Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150;

(5) Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired consumers and limited English proficient consumers;

(6) Bring services to the consumer or locate services at sites where transportation is available to consumers; and

(7) Ensure compliance with all state and federal nondiscrimination laws, rules and plans.

[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, § 388-865-0415, filed 5/31/01, effective 7/1/01.]

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 evalu-

ation 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.]

WAC 388-865-0425 Individual service plan. Community support service providers must provide consumers with an individual service plan that meets his or her unique needs. Individualized and tailored care is a planning process that may be used to develop a consumer-driven, strength-based, individual service plan. The individual service plan must:

(1) Be developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable;

(2) Address age, cultural, or disability issues of the consumer;

(3) Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate;

(4) Demonstrate that the provider has worked with the consumer and others at the consumer's request to determine his/her needs in the following life domains:

(a) Housing;

(b) Food;

(c) Income;

(d) Health and dental care;

(e) Transportation;

(f) Work, school or other daily activities;

(g) Social life; and

(h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

(5) Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional. If the person developing the plan is not a mental health specialist required per WAC 388-865-405(5) there must also be documented consultation with the appropriate mental health specialist(s);

(6) Document review and update at least every one hundred eighty days or more often at the request of the consumer;

(7) In the case of children:

(a) Be integrated with the individual education plan from the education system whenever possible;

(b) If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436.

[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, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0430 Clinical record. The community support service provider must maintain a clinical record for each consumer and safeguard the record against loss, defacement, tampering, or use by unauthorized persons. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the consumer;

(3) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(4) The crisis treatment plan when appropriate;

(5) The individualized service plan and all changes in the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation that services are provided by, or under the clinical supervision, or the clinical consultation of a mental health specialist. Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist;

(8) Periodic documentation of the course of treatment and objective progress toward established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices;

(9) A notation of extraordinary events affecting the consumer;

(10) Documentation of mandatory reporting of abuse, neglect, or exploitation of consumers consistent with chapters 26.44 and 74.34 RCW;

(11) Documentation that the department of corrections was notified by the provider when a consumer on an less restrictive alternative or department of corrections order mental health treatment informs them that they are under supervision by department of corrections. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax. The disclosure to department of corrections does not require the person's consent;

(12) If the consumer has been given relief by the committing court it must be confirmed in writing;

(13) When the mental health provider becomes aware of a violation that relates to public safety of court ordered treatment of a consumer who is both in a less restrictive alternative and is being supervised by the department of corrections, documentation that an evaluation by a designated mental health professional was requested;

(14) Documentation of informed consent to treatment and medications by the consumer or legally responsible other;

(15) Documentation of confidential information that has been released without the consent of the consumer including, but not limited to provisions in RCW 70.02.050, 71.05.390 and 71.05.630.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0430, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0430, 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, § 388-865-0430, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0435 Consumer access to their clinical record. The service provider must provide access to clinical records for consumers, their designated representative, and/or the person legally responsible for the consumer, consistent with chapters 71.05, 70.02, and 71.34 RCW and RCW 13.50.400 (4)(b) for children. The provider must:

(1) Make the record available within fifteen days;

(2) Review the clinical record to identify and remove any material confidential to another person, agency, provider or reports not originated by the community support service provider;

(3) Allow the consumer appropriate time and privacy to review the clinical record;

(4) Provide a clinical staff member to answer questions at the request of the consumer; and

(5) Charge for copying at a rate not higher than that defined in RCW 70.02.010(12).

[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, § 388-865-0435, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0436 Clinical record access procedures. The community support service provider must develop policies and procedures to protect information and to ensure that information about consumers is shared or released only in compliance with state and federal law (see chapters 70.02, 71.05, 71.34, 74.04 RCW and RCW 13.50.100 (4)(b)) and this chapter.

[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, § 388-865-0436, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0440 Availability of consumer information. (1) Consumer individualized crisis plans as provided by the consumer must be available twenty-four hours a day, seven days a week to designated mental health professionals, crisis teams, and voluntary and involuntary inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(2) Consumer information must be available to the state and regional support network staff as required for management information, quality management and program review.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0440, filed 8/18/06, effective 9/18/06. 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, § 388-865-0440, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0445 Establishment of procedures to bill for services. Consumers receiving services or the parent(s) of a person under the age of eighteen, the legal guardian, or the estate of the individual is responsible for payment for services received. The provider must establish policies and procedures to:

(1) Bill all third-party payors and private pay consumers. Persons eligible for the medicaid program are not to be billed for medically necessary covered services.

(2) Develop a written schedule of fees that considers the consumer's available income, family size, allowable deductions and exceptional circumstances:

(a) Payment must not be required from consumers whose income is below TANF standards as defined in WAC 388-478-0020;

(b) The fee schedule must be posted in the agency and available to provider staff, consumers, the regional support network, and the mental health prepaid health plan.

[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, § 388-865-0445, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0450 Quality management process. Community support service providers must ensure continued progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes, including objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices by maintaining an internal quality management process. The process must:

(1) Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;

(2) Review the work of persons providing mental health services at least annually; and

(3) Continuously collect, maintain, and use information to correct deficiencies and improve services. Such data must include but is not limited to reports of serious and emergent

incidents as well as grievances filed by consumers or their representatives.

[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, § 388-865-0450, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0452 Emergency crisis intervention services—Additional standards. The community support service provider that is licensed for emergency crisis intervention services must assure that required general minimum standards for community support services are met, plus the additional minimum requirements:

(1) Availability of staff to respond to crises twenty-four hours a day, seven days a week, including:

(a) Bringing services to the person in crisis when clinically indicated;

(b) Requiring that staff remain with the consumer in crisis to stabilize and support him/her until the crisis is resolved or a referral to another service is accomplished;

(c) Resolving the crisis in the least restrictive manner possible;

(d) A process to include family members, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis; and

(e) Written procedures for managing assaultive and/or self-injurious patient behavior.

(2) Crisis telephone screening;

(3) Mobile outreach and stabilization services with trained staff available to provide in-home or in-community stabilization services, including flexible supports to the person where he/she lives.

(4) Provide access to necessary services including:

(a) Medical services, which means at least emergency services, preliminary screening for organic disorders, prescription services, and medication administration;

(b) Interpretive services to enable staff to communicate with consumers who have limited ability to communicate in English, or have sensory disabilities;

(c) Mental health specialists for children, elderly, ethnic minorities or consumers who are deaf or developmentally disabled;

(d) Voluntary and involuntary inpatient evaluation and treatment services, including a written protocol to assure that consumers who require involuntary inpatient services are transported in a safe and timely manner;

(e) Investigation and detention to involuntary services under chapter 71.05 RCW for adults and chapter 71.34 RCW for children who are thirteen years of age or older, including written protocols for contacting the designated mental health professional.

(5) Document all telephone and face-to-face crisis response contacts, including:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from the initial contact to face-to-face response; and

(d) Outcomes, including basis for decision not to respond in person, follow-up contacts made, and referrals made.

(6) The provider must have a written protocol for referring consumers to a voluntary or involuntary inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated mental health professional and transporting consumers.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0452, filed 8/18/06, effective 9/18/06. 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, § 388-865-0452, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0453 Peer support services. (1) Peer support services are a wide range of scheduled activities to assist consumers in exercising control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports and maintenance of community living skills). Peer support services may include but are not limited to self-help support groups, telephone support lines, drop-in centers, and sharing of the peer counselor's own life experiences. Services must be limited to four hours per day per consumer.

(2) The community support service provider that is licensed to provide peer support services must assure that all general minimum standards for community support services are met.

(3) Services must be provided by a peer counselor who has been certified consistent with WAC 388-865-0107 and who discloses him/herself to be a consumer of mental health services.

(4) Services must be documented in the clinical record at least monthly, including objective progress toward goals established in the individual service plan.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0453, filed 8/22/05, effective 9/22/05.]

WAC 388-865-0454 Provider of crisis telephone services only. This section applies only to organizations that receive public mental health funds for the purpose of providing crisis telephone services but are not licensed community support providers. In order to be licensed to provide crisis telephone services, the following requirements must be met:

(1) Staff available to respond to crisis calls twenty-four hours a day, seven days a week;

(2) The agency must assure communication and coordination with the consumer's case manager or primary care provider;

(3) The agency must assure that staff are aware of and protect consumer rights as described in WAC 388-865-0410;

(4) The following sections of WAC subsections apply:

(a) WAC 388-865-0405, Competency requirements for staff;

(b) WAC 388-865-0410, Consumer rights;

(c) WAC 388-865-0440, Availability of consumer information;

(d) WAC 388-865-0450, Quality management process;

(e) WAC 388-865-0452 (6)(a) thru (d), Emergency crisis intervention services—Additional standards;

(f) WAC 388-865-0468, The process for licensing service providers;

(g) WAC 388-865-0472, Licensing categories;

(h) WAC 388-865-0474, Fees for community support licensure;

(i) WAC 388-865-0476, Licensure based on deemed status;

(j) WAC 388-865-0478, Renewal of the provider license;

(k) WAC 388-865-0480, Procedures to suspend or revoke a license;

(l) WAC 388-865-0482, Procedures to contest a licensing decision.

[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, § 388-865-0454, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0456 Case management services—Additional standards. The community support service provider for case management services must assure that all general minimum standards for community support services and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in their individualized service plan;

(2) Support consumer employment, education or participation in other daily activities appropriate to their age and culture;

(3) Make referrals to other needed services and supports, including treatment for co-occurring disorders and health care;

(4) Assist consumers to resolve crises in least-restrictive settings;

(5) Provide information and education about the consumer's illness so the consumer and family and natural supports are engaged to help consumers manage the consumer's symptoms;

(6) Include, as necessary, flexible application of funds, such as rent subsidies, rent deposits, and in-home care to enable stable community living.

[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, § 388-865-0456, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0458 Psychiatric treatment, including medication supervision—Additional standards. The licensed community support service provider for psychiatric treatment, including medication supervision must meet all general minimum standards for community support in addition to the following minimum requirements:

(1) Document the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Document that consumers and, as appropriate, family members are informed about the medication and possible side effects in language that is understandable to the consumer, and referred to other health care facilities for treatment of nonpsychiatric conditions;

(2) Provider staff must inspect and inventory medication storage areas at least quarterly:

(a) Medications must be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items must be kept in a separate container with proper security;

(c) No outdated medications must be retained, and medications must be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use must be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials must be stored separately.

(3) Medical direction and responsibility is assigned to a physician who is licensed to practice under chapter 18.57 or 18.71 RCW, and is board-certified or -eligible in psychiatry;

(4) Medications are only prescribed and administered by persons consistent with their license and related requirements;

(5) Medications are reviewed at least every three months;

(6) Medication information is maintained in the clinical record and documents at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of giving medication;

(c) Dates prescribed, reviewed, and renewed;

(d) The effects, interactions, and side effects the staff observes or the consumer reports spontaneously or as the result of questions from the staff;

(e) Any laboratory findings;

(f) Reasons for changing or stopping the medication; and

(g) Name and signature of prescribing person.

(7) Assessment and appropriate referrals to or consultation with a physician or other health care provider when physical health problems are suspected or identified;

(8) Address current medical concerns consistent with the individualized service plan;

(9) If the service provider is unable to employ or contract with a psychiatrist, a physician without board eligibility in psychiatry may be utilized, provided that:

(a) Psychiatrist consultation is provided to the physician at least monthly; and

(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.

[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, § 388-865-0458, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0460 Counseling and psychotherapy services—Additional standards. The licensed community support service provider for counseling and psychotherapy services must assure that all general minimum standards for community support are met.

[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, § 388-865-0460, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0462 Day treatment services—Additional standards. The licensed community support service provider for day treatment services must assure that all general minimum standards for community support are met. Day treatment services are defined as work or other activities of daily living for consumers:

(1) Services for adults include:

(a) Training in basic living and social skills;

(b) Supported work and preparation for work;
(c) Vocational rehabilitation;
(d) Day activities; and, if appropriate;
(e) Counseling and psychotherapy services.
(2) Services for children include:
(a) Age-appropriate living and social skills;
(b) Educational and prevocational services;
(c) Day activities; and
(d) Counseling and psychotherapy services.

[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, § 388-865-0462, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0464 Consumer employment services—Additional standards. The community support service provider licensed for employment services must assure that all general minimum standards for community support and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

(a) A vocational assessment of work history, skills, training, education, and personal career goals;

(b) Information about how employment will affect income and benefits the consumer is receiving because of their disability;

(c) Active involvement with consumers served in creating and revising individualized job and career development plans;

(d) Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;

(e) Integrated supported employment, including outreach/job coaching and support in a normalized or integrated worksite, if required; and

(f) Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Antidiscrimination law.

(2) Pay consumers according to the Fair Labor Standards Act; and ensure safety standards that comply with local and state regulations are in place if the provider employs consumers as part of the prevocational or vocational program;

(3) Coordinate efforts with other rehabilitation and employment services, such as:

(a) The division of vocational rehabilitation;
(b) The state employment services;
(c) The business community; and
(d) Job placement services within the community.

[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, § 388-865-0464, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0465 Adult residential treatment facility certification—Additional standards. In order to be certified to provide services at an adult residential treatment facility, the licensed mental health agency must assure that all general minimum standards for community support are met, and in addition:

(1) Be licensed as a mental health adult residential treatment facility by the department of health under chapter 246-337 WAC; and

(2) Be certified to provide services to a consumer on a less restrictive alternative court order consistent with WAC 388-865-0466.

[Statutory Authority: RCW 71.05.560. 04-12-043, § 388-865-0465, filed 5/28/04, effective 6/28/04. Statutory Authority: RCW 71.05.560 and chapter 71.05 RCW. 04-01-091, § 388-865-0465, filed 12/16/03, effective 1/16/04.]

WAC 388-865-0466 Community support outpatient certification—Additional standards. In order to provide services to consumers on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Document in the consumer clinical record and otherwise ensure:

(a) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 RCW and as follows:

(i) To receive adequate care and individualized treatment;

(ii) To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the consumer has the right to attend;

(iii) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

(iv) Of access to attorneys, courts, and other legal redress;

(v) To have the right to be told statements the consumer makes may be used in the involuntary proceedings; and

(vi) To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapters 71.05 and 71.34 RCW.

(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

(i) At least weekly during the fourteen-day period;

(ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

(a) Contacting the designated mental health professional regarding revocations and extension of less restrictive alternatives, and

(b) Transporting consumers.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0466, filed 8/18/06, effective 9/18/06. 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, § 388-865-0466, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0468 Emergency crisis intervention services certification—Additional standards. In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Be available seven-days-a-week, twenty-four-hours-per-day;

(2) Follow a written protocol for holding a consumer and contacting the designated mental health professional;

(3) Provide or have access to necessary medical services;

(4) Have a written agreement with a certified inpatient evaluation and treatment facility for admission on a seven day a week, twenty-four hour per day basis; and

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0468, filed 8/18/06, effective 9/18/06. 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, § 388-865-0468, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0470 The process for initial licensing of service providers. An applicant for a community support license must comply with the following process:

(1) Complete and submit an application form, along with the required fee to the mental health division. A copy of the application form must be provided to the area regional support network. The regional support network may make written comments to the mental health division about the provider's application for licensure. The application must indicate the service components the applicant wants to offer, as listed in WAC 388-865-0400;

(2) A regional support network may submit an application to the mental health division to operate as a licensed community support service provider as defined in WAC 388-865-0288;

(3) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(4) The consumer chart review is conducted during a second site review within twelve months of the issuance of the provisional license for the agency or service component if the site review is being conducted in response to a license application for a new agency or a new service component in a currently licensed agency;

(5) The mental health division may include representatives of the regional support network or mental health prepaid health plan in the licensing review process. If a provider is licensed based on deemed status as outlined in WAC 388-865-0476, input from the accrediting agency may be considered;

(6) The on-site review concludes with an exit conference that includes:

(a) Discussion of findings, if any;

(b) Statement of deficiencies requiring a plan of correction;

(c) A plan of correction signed by the applicant agency director and the mental health division review team representative with a completion date no greater than sixty days from the date of the exit conference, unless otherwise negotiated with the review team representative. Consumer health and safety concerns may require immediate corrective action.

(7) If the provider fails to correct the deficiencies noted within the agreed-upon time frames, licensure will be denied. The mental health division notifies the applicant in writing of the reasons for denial and the right to a review of the decision in an administrative hearing;

(8) If licensure is denied, the applicant must wait at least six months following the date of notification of denial before reapplying.

[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, § 388-865-0470, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0472 Licensing categories. The mental health division assigns the community support service applicant or licensee one of the following types of licenses:

(1) Provisional license. This category is given only to a new applicant. The mental health division may grant a provisional license for up to one year if the provider, has:

(a) An acceptable detailed plan for the development and operation of the services;

(b) The availability of administrative and clinical expertise required to develop and provide the planned services;

(c) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(d) A corrective action plan approved by the mental health division, if applicable, for any deficiencies.

(2) Full License. Full licensure means that the applicant or licensee is in substantial compliance with the law, applicable rules and regulations, and state minimum standards.

(3) Probationary license. The mental health division may issue a probationary license if the service provider is substantially out of compliance with the requirements of state and federal law, applicable rules and regulations and state minimum standards. The mental health division provides the service provider with a written notice of the deficiencies.

(a) If the deficiency has caused or is likely to cause serious injury, harm, impairment or death to a consumer, the deficiencies must be corrected within a time frame specified by the mental health division;

(b) If the provider fails to complete a corrective action plan or correct deficiencies according to the corrective action plan, the license may be suspended or revoked;

(c) To regain full licensure, a service provider in probationary status must provide a written statement to the mental health division when it has made all required corrective actions and now complies with relevant federal and state law, applicable rules and regulations, and state minimum standards;

(d) The mental health division may conduct an on-site review to confirm that the corrections have been made.

(4) The mental health division may perform an onsite visit to determine the validity of a complaint or notice that a community support service provider is out of compliance with law, applicable rules and regulations, and state minimum standards.

(5) If the service provider does not demonstrate compliance with the requirements of this section, the mental health division may initiate procedures to suspend or revoke a license consistent with state and federal laws, rules and regulations consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.205.

(6) A regional support network or prepaid health plan may choose to contract with a service provider with a provisional license, full license, or probationary license, but may not contract with a provider with a suspended or revoked license.

[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, § 388-865-0472, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0474 Fees for community support service provider licensure. (1) Fees are due with an initial application or for annual license renewal;

(2) Fees must be paid for a minimum of one year;

(3) If an application is withdrawn prior to issuance or denial, one-half of the fees may be refunded at the request of the applicant;

(4) A change in ownership requires a new license and payment of fees;

(5) Fee payments must be made by check, electronic fund transfer, or money order made payable to the mental health division;

(6) Fees will not be refunded if a license or certificate is denied, revoked, or suspended;

(7) Failure to pay fees when due will result in suspension or denial of the license;

(8) The following fees must be sent with the application for a license or renewal:

Range	Service Hours	Annual Fee
1	0-3,999	$291.00
2	4,000-14,999	422.00
3	15,000-29,999	562.00
4	30,000-49,999	842.00
5	50,000 or more	1,030.00

(9) Annual service hours are computed on the most recent year. For new entities, annual service hours equals the projected service hours for the year of licensure. The provider must report the number of annual service hours based on the mental health division consumer information system data dictionary.

[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, § 388-865-0474, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0476 Licensure based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue a community support service license based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency.

(2) The mental health division will only grant licensure based on deemed status to providers with a full license as defined in WAC 388-865-0472.

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law, or regulation will not be waived through a deeming process.

[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, § 388-865-0476, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0478 Renewal of a community support service provider license. (1) Each year the community support service provider must renew its license. The community support service provider sends the reapplication for licensure to mental health division along with the required fee.

(2) If the service provider contracts with the regional support network or prepaid health plan it must send a copy of the application to the regional support network or mental health prepaid health plan. The regional support network or mental health prepaid health plan may make written comments to the mental health division about renewing the service provider's license. They must send the service provider a copy.

(3) The mental health division considers the request for renewal, along with any recommendations from the regional support network or mental health prepaid health plan and the results of any onsite reviews completed.

(4) If the provider is in compliance with applicable laws and standards, the mental health division sends the service provider a renewed license, with a copy to the regional support network or mental health prepaid health plan if applicable.

(5) Failure to submit the annual application for renewal license and/or to pay fees when due results in expiration of the license and the provider will be placed on probationary status.

[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, § 388-865-0478, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0480 Procedures to suspend, or revoke a license. (1) The mental health division may suspend, revoke, limit or restrict the license of a community support service provider, or refuse to grant or renew a license for failure to conform to the law, applicable rules and regulations, or state minimum standards.

(2) The mental health division may suspend, revoke, limit or restrict the license of a service provider immediately if there is imminent risk to consumer health and safety.

(3) The mental health division sends a written decision to revoke, suspend, or modify the former licensure status under RCW 43.20A.205, with the reasons for the decision and informing the service provider of its right to an administrative hearing. A copy of the letter will be sent to the area regional support network.

(4) A regional support network or mental health prepaid health plan must not contract with a service provider with a suspended or revoked license.

(5) The mental health division may suspend or revoke a license when a service provider in probationary status fails to correct the health and safety deficiencies as agreed in the corrective action plan with the mental health division.

[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, § 388-865-0480, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0482 Procedures to contest a licensing decision. To contest a decision by the mental health division, the service provider, regional support network, or mental health prepaid health plan must, within twenty-eight calendar days:

(1) File a written application for a hearing with a method that shows proof of receipt to: The Board of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(2) Include in the appeal:

(a) The issue to be reviewed and the date the decision was made;

(b) A specific statement of the issue and law involved;

(c) The grounds for contesting a decision of the mental health division; and

(d) A copy of the mental health division decision that is being contested.

(3) The appeal must be signed by the director of the service provider and include the address of the service provider.

(4) The decision will be made following the requirements of the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC.

[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, § 388-865-0482, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0484 Process to certify providers of involuntary services. In order to be certified to provide services to consumers on an involuntary basis, the provider must comply with the following process:

(1) Be licensed as a community support provider consistent with this section or licensed as a community hospital by the department of health;

(2) Complete and submit an application for certification to the regional support network or the mental health division if the DSHS secretary has assumed the duties assigned to the nonparticipating regional support network;

(3) The regional support network selects providers for certification and makes a request to the mental health division for certification;

(4) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(5) The mental health division grants certification based on compliance with the minimum standards of this section and chapter 71.05 RCW;

(6) The certificate may be renewed annually if:

(a) Requested by the regional support network or those providers contracted with the mental health division directly; and

(b) The provider continues to comply with the minimum standards of this section;

(7) The procedures to suspend or revoke a certificate are the same as outlined in WAC 388-865-0468;

(8) The appeal process to contest a decision of the mental health decision is the same as outlined in WAC 388-865-0482.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0484, filed 12/30/08, effective 1/30/09. 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, § 388-865-0484, filed 5/31/01, effective 7/1/01.]

SECTION FIVE—INPATIENT EVALUATION AND TREATMENT FACILITIES

WAC 388-865-0500 Inpatient evaluation and treatment facilities. (1) The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours within a general hospital, psychiatric hospital, inpatient evaluation and treatment facility, or child long-term inpatient treatment facility.

(2) Compliance with the regulations in this chapter does not constitute release from the requirements of applicable federal, state, tribal and local codes and ordinances. Where regulations in this chapter exceed other local codes and ordinances, the regulations in this chapter will apply.

(3) This chapter does not apply to state psychiatric hospitals as defined in chapter 72.23 RCW or facilities owned or operated by the department of veterans affairs or other agencies of the United States government.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0500, filed 3/4/04, effective 4/4/04. 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, § 388-865-0500, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0511 Evaluation and treatment facility certification. To obtain and maintain certification to provide inpatient evaluation and treatment services under chapter 71.05 and 71.34 RCW, a facility must meet the following requirements:

(1) Be licensed by the department of health as:

(a) A hospital as defined in chapter 70.41 RCW;

(b) A psychiatric hospital as defined in chapter 246-322 WAC;

(c) A mental health inpatient evaluation and treatment facility consistent with chapter 246-337 WAC; or

(d) A mental health child long-term inpatient treatment facility consistent with chapter 246-337 WAC.

(2) Be approved by the regional support network, or the mental health division. Child long-term inpatient treatment facilities can only be approved by the mental health division.

(3) Successfully complete a provisional and annual on-site review by the mental health division to determine facility compliance with the minimum standards of this section and chapters 71.05 and 71.34 RCW.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0511, filed 12/30/08, effective 1/30/09. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0511, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0516 Certification fees. Inpatient facilities certified to provide inpatient evaluation and treatment services are assessed an annual certification fee of thirty-two dollars per bed, payable to the mental health division.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0516, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0520 Certification based on deemed status. The mental health division may deem compliance with state minimum standards for facilities that are currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division.

(1) Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency, to include the minimum standards of this section and chapters 71.05 and 71.34 RCW.

(2) The mental health division retains all responsibilities relating to applications of new providers, complaint investigations, suspensions and revocations.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0520, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0526 Single bed certification. At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500; or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order. For involuntarily detained or committed children, the exception may be granted to allow treatment in a facility not certified under WAC 388-865-0500 until the child's discharge from that setting to the community, or until they transfer to a bed in a children's long-term inpatient program (CLIP).

(1) The regional support network or its designee must submit a written request for a single bed certification to the mental health division prior to the commencement of the order. In the case of a child, the facility must submit the written request directly to the mental health division. If the DSHS secretary has assumed the duties assigned to a nonparticipating regional support network, a single bed certification may be requested by a mental health division designee contracted to provide inpatient authorization or designated crisis response services.

(2) The facility receiving the single bed certification must meet all requirements of this section unless specifically waived by the mental health division.

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a facility certified under this chapter or a state psychiatric hospital; or

(b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

(4) The mental health division director or the director's designee makes the decision and gives written notification to the requesting entity in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal law or state statute.

(5) The mental health division may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of this exception may result in corrective action. If the mental health division determines that the violation places consumers in imminent jeopardy, immediate revocation of this exception can occur.

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by mental health division staff.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. 09-02-030, § 388-865-0526, filed 12/30/08, effective 1/30/09. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0526, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0531 Exception to rule—Long-term certification. (1) For adults: At the discretion of the mental health division, a facility may be granted an exception to WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on a ninety- or one hundred eighty-day inpatient involuntary commitment orders.

(2) For children: At the discretion of the mental health division, a facility that is certified as a 'mental health inpatient evaluation and treatment facility' may be granted an exception to provide treatment to a child on a one hundred and eighty-day inpatient involuntary treatment order only until the child is discharged from his/her order to the community, or until a bed is available for that child in a child long-term inpatient treatment facility (CLIP). The child cannot be assigned by the CLIP placement team in accordance with RCW 71.34.100 to any facility other than a CLIP facility.

(3) The exception certification may be requested by the facility, the director of the mental health division or his/her designee, or the regional support network for the facility's geographic area.

(4) The facility receiving the long-term exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in WAC 388-865-0500.

(5) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of

consumers allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of residents.

(6) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action. If the mental health division determines that the violation places residents in imminent jeopardy, immediate revocation of the certification can occur.

(7) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding the decision to grant or not to grant exception certification.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0531, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0536 Standards for administration. The inpatient evaluation and treatment facility must develop a policy to implement the following administrative requirements:

(1) A description of the program, including age of consumers to be served, length of stay and services to be provided.

(2) An organizational structure including clear lines of authority for management and clinical supervision.

(3) Designation of a physician or other mental health professional as the professional person in charge of clinical services at that facility.

(4) A quality management plan to monitor, collect data and develop improvements to meet the requirements of this chapter.

(5) A policy management structure that establishes:

(a) Procedures for maintaining and protecting resident medical/clinical records consistent with chapter 70.02 WAC, "Medical Records Health Care Information Access and Disclosure Act" and Health Insurance Portability and Accountability Act (HIPAA);

(b) Procedures for maintaining adequate fiscal accounting records consistent with generally accepted accounting principles (GAAP);

(c) Procedures for management of human resources to ensure that residents receive individualized treatment or care by adequate numbers of staff who are qualified and competent to carry out their assigned responsibilities;

(d) Procedures for admitting consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day, except that child long-term inpatient treatment facilities are exempted from this requirement;

(e) Procedures to assure appropriate and safe transportation for persons who are not approved for admission to his or her residence or other appropriate place;

(f) Procedures to detain arrested persons who are not approved for admission for up to eight hours in order to enable law enforcement to return to the facility and take the person back into custody;

(g) Procedures to assure access to necessary medical treatment, emergency life-sustaining treatment, and medication;

(h) Procedures to assure the protection of consumer and family rights as described in this chapter and chapters 71.05 and 71.34 RCW;

(i) Procedures to inventory and safeguard the personal property of the consumer being detained, including a process to limit inspection of the inventory list by responsible relatives or other persons designated by the detained consumer;

(j) Procedures to assure that a mental health professional and licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(k) Procedures to provide warning to an identified person and law enforcement when an adult has made a threat against an identified victim;

(l) Procedures to ensure that consumers detained for up to fourteen or ninety additional days of treatment are evaluated by the professional staff of the facility in order to be prepared to testify that the consumer's condition is caused by a mental disorder and either results in likelihood of serious harm or the consumer being gravely disabled;

(m) Procedures to assure the rights of consumers to make mental health advance directives, and facility protocols for responding to consumer and agent requests consistent with RCW 71.32.150.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0536, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0541 Admission and intake evaluation. (1) For consumers who have been involuntarily detained, the facility must obtain a copy of the petition for initial detention stating the evidence under which the consumer was detained.

(2) The facility must document that each resident has received timely evaluations to determine the nature of the disorder and the treatment necessary, including:

(a) A health assessment of the consumer's physical condition to determine if the consumer needs to be transferred to an appropriate hospital for treatment;

(b) Examination and medical evaluation within twenty-four hours by a licensed physician, advanced registered nurse practitioner, or physician assistant-certified;

(c) Psychosocial evaluation by a mental health professional;

(d) Development of an initial treatment plan;

(e) Consideration of less restrictive alternative treatment at the time of admission; and

(f) The admission diagnosis and what information the determination was based upon.

(3) A consumer who has been delivered to the facility by a peace officer for evaluation must be evaluated by a mental health professional within the following time frames:

(a) Three hours of an adult consumer's arrival;

(b) Twelve hours of arrival for a child in an inpatient evaluation and treatment facility; or

(c) At any time for a child who has eloped from a child long-term inpatient treatment facility and is being returned to the facility.

(4) If the licensed physician and mental health professional determine that the needs of an adult consumer would be better served by placement in a chemical dependency treatment facility then the consumer must be referred to an

approved treatment program defined under chapter 70.96A RCW.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0541, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0545 Use of seclusion and restraint procedures—Adults. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;

(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;

(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;

(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;

(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.

[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, § 388-865-0545, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0546 Use of seclusion and restraint procedures—Children. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;

(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;

(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours must be recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion.

[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, § 388-865-0546, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0547 Plan of care/treatment. The medical record must contain documentation of:

(1) Diagnostic and therapeutic services prescribed by the attending clinical staff.

(2) An individualized plan for treatment developed collaboratively with the consumer. This may include participation of a multidisciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer.

(3) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(4) A plan for discharge including a plan for follow-up where appropriate.

(5) Documentation of the course of treatment.

(6) That a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation;

(c) Release from involuntary commitment to accept treatment on a voluntary basis;

(d) Discharge from the facility to accept voluntary treatment upon referral.

(7) For consumers who are being evaluated as dangerous mentally ill offenders under RCW 72.09.370(7), the professional person in charge of the evaluation and treatment facility must consider filing a petition for a ninety day less restrictive alternative in lieu of a petition for a fourteen-day commitment.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0547, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0551 Qualification requirements for staff. The provider must document that staff and clinical supervisors are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

(1) A current job description.

(2) A current Washington state department of health license or certificate or registration as may be required for his/her position.

(3) Washington state patrol background checks for employees in contact with consumers consistent with RCW 43.43.830.

(4) Clinical supervisors must meet the qualifications of mental health professionals or specialists as defined in WAC 388-865-0150.

(5) An annual performance evaluation.

(6) Development of an individualized annual training plan, to include at least:

(a) The skills he or she needs for his/her job description and the population served;

(b) Least restrictive alternative options available in the community and how to access them;

(c) Methods of resident care;

(d) Management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and/or restraint procedures; and

(e) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.

(7) If contract staff are providing direct services, the facility must ensure compliance with the training requirements outlined in (6) above.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0551, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0561 Posting of consumer rights. The consumer rights assured by RCW 71.05.370 and 71.34.160 must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility and provided in writing to the consumer, as follows: "You have the right to:

(1) Immediate release, unless involuntary commitment proceedings are initiated.

(2) Wear your own clothes and to keep and use personal possessions, except when deprivation is essential to protect your safety or that of another person.

(3) Keep and be allowed to spend a reasonable sum of your own money for canteen expenses and small purchases.

(4) Adequate care and individualized treatment.

(5) Have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential.

(6) Have access to individual storage space for your private use.

(7) Have visitors at reasonable times.

(8) Have reasonable access to a telephone, both to make and receive confidential calls.

(9) Have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mails.

(10) Not to consent to the administration of anti-psychotic medications beyond the hearing conducted pursuant to RCW 71.05.320(2) or the performance of electroconvulsant therapy or surgery, except emergency life-saving surgery, unless ordered by a court of competent jurisdiction pursuant to the following standards and procedures: RCW 71.05.200 (1)(e); 71.05.215; and 71.05.370(7).

(11) To dispose of property and sign contracts unless you have been adjudicated as incompetent in a court proceeding directed to that particular issue.

(12) Not to have psychosurgery performed under any circumstances."

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0561, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0566 Rights of consumers receiving involuntary services. The provider must ensure that consumers who are receiving inpatient services involuntarily are informed of the following rights orally and provided with a copy in the primary language spoken/used/understood by the person. "You have the right to:

(1) Remain silent and any statement you make may be used against you.

(2) Access to attorneys, courts and other legal redress, including the name and address of the attorney the mental health professional has designated for you.

(3) Immediately be informed of your right to speak with an attorney and a review of the legality of your detention including representation at the probable cause hearing.

(4) Have access to a qualified language interpreter in the primary language understood by you, consistent with chapter 388-03 WAC.

(5) Have a responsible member of your immediate family if possible, guardian or conservator, if any, and such person as designated by you be given written notice of your inpatient status, and your rights as an involuntary consumer.

(6) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary.

(7) A judicial hearing before a superior court if you are not released within seventy-two hours (excluding Saturday, Sunday, and holidays), to decide if continued detention within the facility is necessary.

(8) Not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided.

(9) Not to be denied treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.

(10) Refuse psychiatric medication, except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber.

(11) Refuse treatment, but not emergency lifesaving treatment unless otherwise specified in a written advance directive provided to the facility.

(12) Be given a copy of WAC 388-865-0585 outlining limitations on the right to possess a firearm."

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0566, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0570 Rights related to antipsychotic medication. All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.370(7) and 71.05.-215. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) The clinical record must document:

(a) The physician's attempt to obtain informed consent;

(b) The consumer was asked if he or she wishes to decline treatment during the twenty-four hour period prior to any court proceeding wherein the consumer has the right to attend and is related to his or her continued treatment. The answer must be in writing and signed when possible. In the case of a child under the age of eighteen, the physician must be able to explain to the court the probably effects of the medication.

(c) The reasons why any anti-psychotic medication is administered over the consumer's objection or lack of consent.

(2) The physician may administer anti-psychotic medications over a consumer's objections or lack of consent only when:

(a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:

(i) The consumer presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.

(b) There is an additional concurring opinion by a second physician for treatment up to thirty days;

(c) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.370(7), provided the facility medical director or director's medical designee reviews the decision to medicate a consumer. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.

(3) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7);

(4) Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the involuntary administration of antipsychotic medications;

(5) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(6) All involuntary medication orders must be consistent with the provisions of RCW 71.05.370 (7)(a) and (b), whether ordered by a physician or the court.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0570, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0575 Special considerations for serving children. Inpatient evaluation and treatment facilities serving children must develop policies and procedures to address special considerations for serving children, including:

(1) Adults must be separated from children who are not yet thirteen years of age;

(2) Children who have had their thirteenth birthday, but are under the age of eighteen, may be served with adults only if the child's clinical record contains a professional judgment saying that placement in an adult facility will not be harmful to the child or adult.

(3) Examination and evaluation by a children's mental health specialist within twenty-four hours of admission.

(4) Provisions for evaluation of children brought to the facility for evaluation by their parents.

(5) Procedures to notify child protective services any time the facility has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of a child has occurred.

(6) For a child thirteen years or older who is brought to an inpatient evaluation and treatment facility or hospital for immediate mental health services, the professional person in charge of the facility must evaluate the child's mental condition, determine a mental disorder, need for inpatient treatment, and willingness to obtain voluntary treatment. The facility may detain or arrange for the detention of the child up to twelve hours for evaluation by a designated mental health professional to commence detention proceedings.

(7) Admission of children thirteen years or older admitted without parental consent must have concurrence of the professional person in charge of the facility and written review and documentation no less than every one hundred eighty days.

(8) Notice must be provided to parents when a child is voluntarily admitted to inpatient treatment without parental consent within twenty-four hours of admission in accordance with the requirements of RCW 71.34.510.

(9) Children who have been admitted on the basis of a designated mental health professional petition for detention must be evaluated by the facility providing seventy two hour evaluation and treatment to determine the child's condition and either admit or release the child. If the child is not approved for admission, the facility must make recommendations and referral for further care and treatment as necessary.

(10) Examination and evaluation of a child approved for inpatient admission to include:

(a) The needs to be served by placement in a chemical dependency facility;

(b) Restricting the right to associate or communicate with parents; and

(c) Advising the child of rights in accordance with chapter 71.34 RCW.

(11) Petition for fourteen-day commitment in accordance with the requirements of RCW 71.34.730.

(12) Commitment hearing requirements and release from further inpatient treatment which may be subject to reasonable conditions if appropriate in accordance with RCW 71.34.740.

(13) Discharge and conditional release of a child in accordance with RCW 71.34.770, provided that the professional person in charge gives the court written notice of the release within three days of the release. If the child is on a one hundred eighty-day commitment, the children's long-term inpatient program administrator must also be notified.

(14) Rights of children undergoing treatment and posting of such rights must be in accordance with RCW 71.34.355, 71.34.620, and 71.34.370.

(15) Release of a child who is not accepted for admission or who is released by an inpatient evaluation and treatment facility in accordance with RCW 71.34.365.

(16) Information concerning treatment of children and all information obtained through treatment under this chapter may be disclosed only in accordance with RCW 71.34.340.

(17) Availability of court records and files in accordance with RCW 71.34.335.

(18) Mental health services information must only be released in accordance with RCW 71.34.345 and other applicable state and federal statutes.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0575, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0575, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0580 Child long-term inpatient treatment facilities. Child long-term inpatient treatment facilities must develop a written plan for assuring that services provided are appropriate to the developmental needs of children and youth, including:

(1) If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.

(2) There must be a psychologist with documented evidence of skill and experience in working with children and youth available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.

(3) There must be a registered nurse, with training and experience in working with psychiatrically impaired children and youth, on staff as a full-time or part-time employee who must be responsible for all nursing functions.

(4) There must be a social worker with experience in working with children and youth on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individualized treatment plan.

(5) There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.

(6) There must be an occupational therapist available who has experience in working with psychiatrically impaired children and youth responsible for occupational therapy functions and the integration of these functions into treatment.

(7) There must be a recreational therapist available who has had experience in working with psychiatrically impaired children and youth responsible for the recreational therapy functions and the integration of these functions into treatment.

(8) Disciplinary policies and practices must be stated in writing:

(a) Discipline must be fair, reasonable, consistent and related to the behavior of the resident. Discipline, when needed, must be consistent with the individualized treatment plan;

(b) Abusive, cruel, hazardous, frightening or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used;

(c) Disciplinary measures must be documented in the medical record.

(9) Residents must be protected from assault, abuse and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty or neglect to a child must be reported to a law enforcement agency or to the department of social and health services and comply with chapter 26.44 RCW.

(10) Orientation material must be made available to facility personnel, clinical staff and/or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police and department phone numbers must be available to personnel and staff.

(11) When suspected or alleged abuse is reported, the medical record must reflect the fact that an oral or written report has been made to the child protective services of DSHS or to a law enforcement agency. This note must include the date and time that the report was made, the agency to which it was made and the signature of the person making the report. Contents of the report need not be included in the medical record.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0580, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0585 Petition for the right to possess a firearm. An adult is entitled to the restoration of the right to firearm possession when he or she no longer requires treatment or medication for a condition related to the involuntary commitment. This is described in RCW 9.41.047 (3)(a).

(1) an adult who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings and conclusions of law.

(2) The person must show the court that he/she no longer requires treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0585, filed 3/4/04, effective 4/4/04.]

SECTION SIX—DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

WAC 388-865-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

[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, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0610 Definitions. Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1) **"Relevant records and reports"** means:

(a) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the records and reports;

(ii) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports;

(iii) Inpatient psychiatric assessment - Any initial, interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multidisciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan data base - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(vii) Forensic discharge review - A report completed by a state hospital for individuals admitted for evaluation or treatment who have transferred from a correctional facility or is or has been under the supervision of the department of corrections.

(b) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: Documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through 388-865-0430, or equivalent document as established by the holders of the records and reports;

(iii) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v) Outpatient treatment plan - A document designed to guide multidisciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii) Name, address and telephone number of the case manager or primary clinician.

(d) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: Occupational therapy evaluations, rehabilitative services data base activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: Duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnaping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.120, 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii) Risk assessment - Any tests or formal evaluations including department of corrections risk assessments administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court

indicating current legal status or legal obligations including, but not limited to:

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34 RCW;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

(2) **"Relevant information"** means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0610, 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, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes including risk assessments release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0620, 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, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0630 Time frame. The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(3) Emergent situation requests - When an offender subject has failed to report for department of corrections supervision or in an emergent situation that poses a significant risk to the public, the mental health provider shall upon request, release information related to mental health services delivered to the offender and, if known, information regarding the whereabouts of the offender. Requests if oral must be subsequently confirmed in writing the next working day, which includes e-mail or facsimile so long as the requesting person at the department of corrections is clearly defined. The request must specify the information being requested. Disclosure of the information requested does not require the consent of consumer.

(a) Information that can be released is limited to:

(i) A statement as to whether the offender is or is not being treated by the mental health services provider; and

(ii) Address or information about the location or whereabouts of the offender.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0630, 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, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0640 Written requests. The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6) Name, title and signature of the requestor and date of the request.

[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, § 388-865-0640, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0700 Clubhouse certification. The mental health division certifies clubhouses under the provision of RCW 71.24.035. International center for clubhouse development certification is not a substitute for certification by the state of Washington.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0700, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0705 Definitions. The following definitions apply to clubhouse certification rules:

"Absentee coverage"—The clubhouse provides a temporary replacement for the clubhouse member who is currently employed in a time-limited, part-time community job managed by the clubhouse.

"Certification"—Official acknowledgement from the mental health division that an organization meets all state standards to operate as a clubhouse, and demonstrates that those standards have been implemented.

"Clubhouse"—A community-based, recovery-focused program designed to support individuals living with the effects of mental illness, through employment, shared contributions, and relationship building. A clubhouse operates under the fundamental principle that everyone has the potential to make productive contributions by focusing on the strengths, talents, and abilities of all members and fostering a sense of community and partnership.

"Recovery"—The process in which people are able to live, work, learn, and participate fully in their communities (RCW 71.24.025).

"Work-ordered day"—A model used to organize clubhouse activities during the clubhouse's normal working hours. Members and staff are organized into one or more work units which provide meaningful and engaging work essential to running the clubhouse. Activities include unit meetings, planning, organizing the work of the day, and performing the work that needs to be accomplished to keep the clubhouse functioning. Members and staff work side-by-side as colleagues. Members participate as they feel ready and according to their individual interests. While intended to provide members with working experience, work in the clubhouse is not intended to be job-specific training, and members are neither paid for clubhouse work nor provided artificial rewards. Work-ordered day does not include medication clinics, day treatment, or other therapy programs.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0705, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0710 Required clubhouse components. Required clubhouse components include all of the following:

(1) Voluntary member participation. Clubhouse members choose the way they use the clubhouse and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members. All member participation is voluntary. Clubhouse policy and procedures must describe how members will have the opportunity to participate, based on their preferences, in the clubhouse.

(2) The work-ordered day.

(3) Activities, including:

(a) Personal advocacy;

(b) Help with securing entitlements;

(c) Information on safe, appropriate, and affordable housing;

(d) Information related to accessing medical, psychological, pharmacological and substance abuse services in the community;

(e) Outreach to members during periods of absence from the clubhouse and maintaining contact during periods of inpatient treatment;

(f) In-house educational programs that use the teaching and tutoring skills of members;

(g) Connecting members with adult education opportunities in the community;

(h) An active employment program that assists members to gain and maintain employment in:

(i) Full- or part-time competitive jobs in integrated settings developed in partnership with the member, the clubhouse, and the employer; and

(ii) Time-limited, part-time community jobs managed by the clubhouse with absentee coverage provided.

(i) An array of social and recreational opportunities.

(4) Operating at least thirty hours per week on a schedule that accommodates the needs of the members.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0710, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0715 Management and operational requirements. The requirements for managing and operating a clubhouse include all of the following:

(1) Members, staff, and ultimately the clubhouse director, are responsible for the operation of the clubhouse. The director must ensure opportunities for members and staff to be included in all aspects of clubhouse operation, including setting the direction of the clubhouse.

(2) Location in an area, when possible, where there is access to local transportation and, when access to public transportation is limited, facilitate alternatives.

(3) A distinct identity, including its own name, mailing address, and phone number.

(4) A separate entrance and appropriate signage that make the clubhouse clearly distinct, when co-located with another community agency.

(5) An independent board of directors capable of fulfilling the responsibilities of a not-for-profit board of directors, when free-standing.

(6) An administrative structure with sufficient authority to protect the autonomy and integrity of the clubhouse, when under the auspice of another agency.

(7) Services are timely, appropriate, accessible, and sensitive to all members.

(8) Members are not discriminated against on the basis of any status or individual characteristic that is protected by federal, state, or local law.

(9) Written proof of a current fire/safety inspection:

(a) Conducted of all premises owned, leased or rented by the clubhouse; and

(b) Performed by all required external authorities (e.g., State Fire Marshall, liability insurance carrier).

(10) All applicable state, county, and city business licenses.

(11) All required and current general liability, board and officers liability, and vehicle insurance.

(12) An identifiable clubhouse budget that includes:

(a) Tracking all income and expenditures for the clubhouse by revenue source;

(b) Quarterly reconciliation of accounts; and

(c) Compliance with all generally accepted accounting principles.

(13) Track member participation and daily attendance.

(14) Assist member in developing, documenting, and maintaining the member's recovery goals and providing monthly documentation of progress toward reaching them.

(a) Both member and staff must sign all such plans and documentation; or

(b) If a member does not sign, staff must document the reason.

(15) A mechanism to identify and implement needed changes to the clubhouse operations, performance, and administration, and to document the involvement of members in all aspects of the operation of the clubhouse.

(16) Evaluate staff performance by:

(a) Ensuring that paid employees:

(i) Are qualified for the position they hold, including any licenses or certifications; and

(ii) Have the education, experience and/or skills to perform the job requirements.

(b) Maintaining documentation that paid clubhouse staff:

(i) Have a completed Washington state patrol background check on file; and

(ii) Receive regular supervision and an annual performance evaluation.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0715, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0720 Certification process. The mental health division (MHD) grants certification based on compliance with the minimum standards set forth in this chapter.

(1) To be certified to provide clubhouse services, an organization must comply with the following:

(a) Meet all requirements for applicable city, county and state licenses and inspections.

(b) Complete and submit an application for certification to MHD.

(c) Successfully complete an on-site certification review by MHD to determine compliance with the minimum clubhouse standards, as set forth in this chapter.

(d) Initial applicants that can show that they have all organizational structures and written policies in place, but lack the performance history to demonstrate that they meet minimum standards, may be granted initial certification for up to one year. Successful completion of an on-site certification review is required prior to the expiration of initial certification.

(2) Upon certification, clubhouses will undergo periodic on-site certification reviews.

(a) The frequency of certification reviews is determined by the on-site review score as follows:

(i) A compliance score of ninety percent or above results in the next certification review occurring in three years;

(ii) A compliance score of eighty percent to eighty-nine percent results in the next certification review occurring in two years;

(iii) A compliance score of seventy percent to seventy-nine percent results in the next certification review occurring in one year; or

(iv) A compliance score below seventy percent results in a probationary certification.

(b) Any facet of an on-site review resulting in a compliance score below ninety percent requires a corrective action plan approved by MHD.

(3) Probationary certification may be issued by MHD if:

(a) A clubhouse fails to conform to applicable law, rules, regulations, or state minimum standards; or

(b) There is imminent risk to consumer health and safety;

(4) MHD may suspend or revoke a clubhouse's certification, or refuse to grant or renew a clubhouse's certification if a clubhouse fails to correct deficiencies as mutually agreed to in the corrective action plan with MHD.

(5) A clubhouse may appeal a certification decision by MHD.

(a) To appeal a decision, the clubhouse must submit a written application asking for an administrative hearing. An application must be submitted through a method that shows written proof of receipt to: Office of Administrative Hearings, P.O. Box 42489, Olympia, WA 98504-2489. An application must be received within twenty-eight calendar days of the date of the contested decision, and must include:

(i) The issue to be reviewed and the date the decision was made;

(ii) A specific statement of the issue and regulation involved;

(iii) The grounds for contesting the decision;

(iv) A copy of MHD's decision that is being contested; and

(v) The name, signature, and address of the clubhouse director.

(b) The hearing decision will be made according to the provisions of chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0720, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0725 Employment-related services—Requirements. The following employment support activities must be offered to clubhouse members:

(1) Collaboration on creating, revising, and meeting individualized job and career goals.

(2) Information about how employment will affect income and benefits.

(3) Information on other rehabilitation and employment services, including but not limited to:

(a) The division of vocational rehabilitation;

(b) The state employment services;

(c) The business community;

(d) Job placement services within the community; and

(e) Community mental health agency-sponsored supported employment services.

(4) Assistance in locating employment opportunities which are consistent with the member's skills, goals, and interests.

(5) Assistance in developing a resume, conducting a job search, and interviewing.

(6) Assistance in:

(a) Applying for school and financial aid; and

(b) Tutoring and completing course work.

(7) Information regarding protections against employment discrimination provided by federal, state, and local laws and regulations, and assistance with asserting these rights, including securing professional advocacy.

[Statutory Authority: RCW 71.24.025, 71.24.035, and 2007 c 414. 08-14-080, § 388-865-0725, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0750 Crisis stabilization unit certification. (1) To obtain and maintain certification as a crisis stabilization unit (defined in RCW 71.05.020) under chapter 71.05 RCW, a facility must:

(a) Be licensed by the department of health;

(b) Ensure that the unit and its services are accessible to all persons, pursuant to federal, state, and local laws; and

(c) Successfully complete a provisional and annual on-site review by the mental health division to determine facility compliance with the minimum standards of this section and chapter 71.05 RCW.

(2) If a crisis stabilization unit is part of a jail, the unit must be located in an area of the building that is physically separate from the general population. "Physically separate" means:

(a) Out of sight and sound of the general population at all times;

(b) Located in an area with no foot traffic between other areas of the building, except in the case of emergency evacuation; and

(c) Has a secured entrance and exit between the unit and the rest of the facility.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0750, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0755 Standards for administration. The crisis stabilization unit must ensure that the following standards for administration are met:

(1) A description of the program, including age of persons to be served, length of stay, and services to be provided.

(2) An organizational structure that demonstrates clear lines of authority for administrative oversight and clinical supervision.

(3) The professional person in charge of administration of the unit is a mental health professional.

(4) A management plan to monitor, collect data and develop improvements to meet the requirements of this chapter.

(5) A policy management structure that establishes:

(a) Procedures for maintaining and protecting personal medical/clinical records consistent with chapter 70.02 WAC, "Medical records—Health care information access and disclosure," and the Health Insurance Portability and Accountability Act (HIPAA);

(b) Procedures for managing human resources to ensure that persons receive individualized evaluation and crisis stabilization services by adequate numbers of staff who are qualified and competent to carry out their assigned responsibilities;

(c) Procedures for ensuring a secure environment appropriate to the legal status of the person(s), and necessary to protect the public safety. "Secure" means having:

(i) All doors and windows leading to the outside locked at all times;

(ii) Visual monitoring, either by line-of-sight or camera as appropriate to the individual;

(iii) Adequate space to segregate violent or potentially violent persons from others;

(iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

(v) Adequate numbers of staff present at all times that are trained in facility security measures.

(d) Procedures for admitting persons needing crisis stabilization services seven days a week, twenty-four hours a day;

(e) Procedures to ensure that for persons who have been brought to the unit involuntarily by police, the stay is limited to twelve hours unless the individual has signed voluntarily into treatment.

(f) Procedures to ensure that within twelve hours of the time of arrival to the crisis stabilization unit, individuals who have been detained by a designated mental health professional or designated crisis responder under chapter 71.05 or 70.96B RCW are transferred to a certified evaluation and treatment facility.

(g) Procedures to assure appropriate and safe transportation of persons who are not approved for admission or detained for transfer to an evaluation and treatment facility, and if not in police custody, to their respective residence or other appropriate place;

(h) Procedures to detain arrested persons who are not otherwise detained and transferred to an evaluation and treatment facility for a period of up to eight hours in order to enable law enforcement to return to the facility and take the person back into custody;

(i) Procedures to ensure access to emergency life-sustaining treatment, necessary medical treatment, and medication;

(j) Procedures to ensure the protection of personal and familial rights as described in WAC 388-865-0561 and chapter 71.05 RCW;

(k) Procedures to inventory and safeguard the personal property of the persons being detained;

(l) Procedures to ensure that a mental health professional (as defined in chapter 388-865 WAC) is on-site twenty-four hours a day, seven days a week;

(m) Procedures to ensure that a licensed physician is available for consultation to direct care staff and patients twenty-four hours a day, seven days a week;

(n) Procedures to provide warning to an identified individual and law enforcement when an individual has made a threat against an identified victim, in accordance with RCW 71.05.390(10);

(o) Procedures to ensure the rights of persons to make mental health advance directives; and

(p) Procedures to establish unit protocols for responding to the provisions of the advanced directives consistent with RCW 71.32.150.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0755, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0760 Admission and intake evaluation. (1) For persons who have been brought to the unit involuntarily by police:

(a) The clinical record must contain:

(i) A statement of the circumstances under which the person was brought to the unit;

(ii) The admission date and time; and

(iii) The date and time when the twelve hour involuntary detention period ends.

(b) The evaluation required in subsection (2)(c) of this section must be performed within three hours of arrival at the facility.

(2) The facility must document that each person has received timely evaluations to determine the nature of the disorder and the services necessary, including at a minimum:

(a) A health screening by an authorized healthcare provider as defined in WAC 246-337-005(22) to determine the healthcare needs of a person.

(b) An assessment for chemical dependency and/or a co-occurring mental health and substance abuse disorder, utilizing the global appraisal of individual needs - short screener (GAIN-SS) or its successor.

(c) An evaluation by a mental health professional to include at a minimum:

(i) Mental status examination;

(ii) Assessment of risk of harm to self, others, or property;

(iii) Determination of whether to refer to a designated mental health professional (DMHP) or designated crisis responder (DCR) to initiate civil commitment proceedings.

(d) Documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person.

(e) Review of the person's current crisis plan, if applicable and available.

(f) The admission diagnosis and what information the determination was based upon.

(3) If the mental health professional determines that the needs of a person would be better served by placement in a chemical dependency treatment facility then the person must be referred to an approved treatment program defined under chapter 70.96A RCW.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0760, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0765 Use of seclusion and restraint procedures within the crisis stabilization unit. (1) Persons have the right to be free from seclusion and restraint, including chemical restraint within the crisis stabilization unit.

(2) The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the person or others from harm. The reasons for the determination must be clearly documented in the clinical record.

(3) The crisis stabilization unit must develop policies and procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others, and in accordance with WAC 246-337-110, 246-322-180, 246-320-745(6), and 388-865-0545.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0765, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0770 Assessment and stabilization services—Documentation requirements. (1) For all persons admitted to the crisis stabilization unit, the clinical record must contain documentation of:

(a) Assessment and stabilization services provided by the appropriate staff;

(b) Coordination with the person's current treatment provider, if applicable;

(c) A plan for discharge, including a plan for follow up that includes:

(i) The name, address, and telephone number of the provider of follow-up services; and

(ii) The follow up appointment date and time, if known.

(2) For persons admitted to the crisis stabilization unit on a voluntary basis, a crisis stabilization plan developed collaboratively with the person within twenty-four hours of admission that includes:

(a) Strategies and interventions to resolve the crisis in the least restrictive manner possible;

(b) Language that is understandable to the person and/or members of the person's support system; and

(c) Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0770, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0775 Qualification requirements for staff. The provider is responsible to ensure that staff and clinical supervisors are qualified for the positions they hold at the crisis stabilization unit.

(1) The provider must document that all staff have:

(a) A current job description.

(b) A current Washington state department of health license or registration as may be required for his/her position.

(c) Washington state patrol background checks for employees in contact with persons consistent with RCW 43.43.830.

(d) An annual performance evaluation.

(e) An individualized annual training plan, to include at minimum:

(i) The skills he or she needs for his/her job description and the population served;

(ii) Training regarding the least restrictive alternative options available in the community and how to access them;

(iii) Methods of person care;

(iv) Management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and/or restraint procedures;

(v) Methods to ensure appropriate security of the facility; and

(vi) Requirements of chapters 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.

(vii) If contract staff is providing direct services, the facility must ensure compliance with the training requirements outlined in subsection (1)(i) through (vii) in this section.

(2) Clinical supervisors must meet the qualifications of mental health professionals as defined in WAC 388-865-0150.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0775, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0780 Posting of rights. The rights outlined in WAC 388-865-0561 must be prominently posted within the crisis stabilization unit and provided in writing to the person.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0780, filed 6/26/08, effective 7/27/08.]

WAC 388-865-0785 Rights related to antipsychotic medications. All persons have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.215 and 71.05.217. The crisis stabilization unit must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) The clinical record must document:

(a) The physician's attempt to obtain informed consent for antipsychotic medication;

(b) The reasons why any antipsychotic medication is administered over the person's objection or lack of consent.

(2) The physician may administer antipsychotic medications over a person's objections or lack of consent only when:

(a) An emergency exists. An emergency exists if:

(i) The person presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the person's condition constitutes an emergency requiring that treatment be instituted before obtaining a concurring opinion by a second physician.

(b) There is a concurring opinion by a second physician for treatment up to thirty days.

[Statutory Authority: RCW 71.05.020, 71.24.035, and 2007 c 375. 08-14-079, § 388-865-0785, filed 6/26/08, effective 7/27/08.]

Chapter 388-875 WAC

CRIMINALLY INSANE PERSON COMMITTED TO THE CARE OF THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—EVALUATION, PLACEMENT, CARE AND DISCHARGE

(Formerly chapter 275-59 WAC)

WAC

WAC 388-875-0010 Purpose. These regulations are adopted pursuant to and in accordance with chapter 117, Laws of 1973 1st ex. sess. They are adopted to provide procedures for the evaluation, placement, care and discharge of persons committed to the care of the department of social and health services, under the aforementioned Act, relating to the criminally insane.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0010, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-010, filed 8/9/73.]

WAC 388-875-0020 Definitions. "Department" means the state department of social and health services.

"Division" means the mental health division, department of social and health services.

"Evaluation" means the initial procedure when a court requests the department to provide an opinion if a person charged with a crime is competent to stand trial or, if indicated and appropriate, if the person was suffering under a mental disease or defect excluding responsibility at the time of the commission of the crime.

"Indigent" means any person who is financially unable to obtain counsel or other necessary expert or professional services without causing substantial hardship to himself or his family.

"Professional person" means:

(1) A psychiatrist. This is defined as a person having a license as a physician and surgeon in this state, who has in addition, completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association and who is certified or is eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) A psychologist. This is defined as a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW.

(3) A social worker. This is defined as a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

"Secretary" means the secretary of the department of social and health services or his designee.

"Superintendent" means the person responsible for the functioning of a treatment facility.

"Treatment facility" means any facility operated or approved by the department of social and health services for the treatment of the criminally insane. Such definition shall not include any state correctional institution or facility.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0020, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-020, filed 3/1/79; Order 846, § 275-59-020, filed 8/9/73.]

WAC 388-875-0030 Mental health division. The secretary designates to the division the responsibility for:

(1) Evaluation and treatment of any person committed to the secretary for evaluation or treatment, under chapter 10.77 RCW;

(2) Assisting the court in obtaining nondepartmental experts or professional persons to participate in the evaluation or a hearing on behalf of the defendant and supervising the procedure whereby such professionals will be compensated, according to fee schedule if the person being evaluated or treated is an indigent;

(3) Assuring that any nondepartmental expert or professional person requesting compensation has maintained adequate evaluation and treatment records which justify compensation;

(4) Assisting the court by designation of experts or professional persons to examine the defendant and report to the court when the defendant is not committed to the secretary;

(5) Determination of what treatment facility shall have custody of persons committed to the secretary under chapter 10.77 RCW.

(6) If the court is advised by any party that the defendant may be developmentally disabled, at least one of the experts or professional persons appointed shall be a developmental disabilities professional.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-030, filed 3/1/79; Order 846, § 275-59-030, filed 8/9/73.]

WAC 388-875-0040 Schedule of maximum payment for defendant expert or professional person. Department payments to an expert or professional person for department services an indigent person receives shall not exceed:

(1) One hundred dollars an hour for services; or

(2) Eight hundred dollars total payment for services.

The department shall only approve an exception to this section ruling when the exception is approved, in writing, by the division director. The department shall only approve payment for one mental health examination per indigent person in each six month period.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0040, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 91-24-045 (Order 3298), § 275-59-041, filed 11/27/91, effective 1/1/92; 79-03-038 (Order 1373), § 275-59-041, filed 3/1/79.]

WAC 388-875-0050 Time limitations and requirements. If a person is committed to the secretary as criminally insane, commitment and treatment cannot exceed the maximum possible sentence for any offense charged. Therefore:

(1) The superintendent, if no superintendent then the division, with the assistance of the office of the attorney general where necessary shall determine at the time of commitment the maximum possible sentence for any offense charged, and thereby compute a maximum release date for every individual so committed.

(2) If the committed person has not been released by court order six months prior to the expiration of the maximum possible release date, the superintendent, if no superintendent, the division, shall notify the committing court and prosecuting attorney of its computation of maximum release date and the requirement that the person must be released on that date unless civil proceedings are instituted or the court determines that the computation of maximum release date is incorrect.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0050, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-050, filed 3/1/79; Order 846, § 275-59-050, filed 8/9/73.]

WAC 388-875-0060 Individualized treatment. (1) Whenever a person is committed to the secretary as criminally insane, the treatment facility to which the person is assigned shall, within fifteen days of admission to the facility, evaluate and diagnose the committed person for the purpose of devising an individualized treatment program.

(2) Every person, committed to the secretary as criminally insane, shall have an individualized treatment plan formulated by the treatment facility. This plan shall be developed by appropriate treatment team members and implemented as soon as possible but no later than fifteen days after the person's admission to the treatment facility as criminally insane. Each individualized treatment plan shall include, but not be limited to:

(a) A statement of the nature of the specific problems and specific needs of the patient;

(b) A statement of the physical setting necessary to achieve the purposes of commitment;

(c) A description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

(d) A statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

(e) A specification of staff responsibility and a description of proposed staff involvement with a patient in order to attain these treatment goals;

(f) Criteria for recommendation to the court for release.

(3) This individualized treatment plan shall be reviewed by the treatment facility periodically, at least every six months, and a copy of the plan shall be sent to the committing court.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0060, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-060, filed 3/1/79; Order 846, § 275-59-060, filed 8/9/73.]

WAC 388-875-0070 Transfer of a patient between state-operated facilities for persons with mental illness. In some instances, it is appropriate for the department to transfer a patient currently residing in a state facility to another state facility for ongoing treatment. The department shall accomplish the transfer with the utmost care given to the therapeutic needs of the patient. This section describes the procedures for handling a patient transfer between state facilities in a manner consistent with the best interest of the patient.

(1) The department may use the following criteria when determining the appropriateness of a patient transfer:

(a) The patient's family resides within the receiving facility's catchment area; or

(b) The patient's primary home of residence is in the receiving facility's catchment area; or

(c) A particular service or need of the patient is better met at the receiving facility; or

(d) Transfer to the receiving facility may facilitate community discharge due to the availability of community service in the receiving facility's catchment area; or

(e) The county, regional support network, or patient requests a transfer.

(2) Prior to any proposed transfer of a patient, the state facility shall comply with the following:

(a) The sending facility, at the request of the superintendent, shall in writing forward information necessary to make a decision on whether transfer is appropriate to the receiving facility's liaison and the regional support network liaison;

(b) The receiving facility's liaison and the regional support network liaison shall recommend appropriate action to the superintendent of the sending facility in writing within five calendar days of receipt of the request;

(c) If the receiving facility accepts the proposed patient transfer, the sending facility shall notify the patient, guardian, regional support network liaison, and attorney, if known, at least five days before the proposed patient transfer;

(d) The sending facility is responsible for all patient transfer arrangements, e.g., transportation, staff escort, etc., and shall coordinate the day and time of arrival with the receiving facility's liaison; and

(e) The sending facility shall arrange for the transfer of patient's medical record to the receiving facility.

(3) The sending state facility shall document the following in the patient's record:

(a) Physician documentation of the medical suitability of the patient for transfer; and

(b) Social worker documentation regarding:

(i) Justification as to why the transfer is considered in the patient's best interests; and

(ii) The patient's wishes regarding transfer.

(4) The sending facility shall contact the prosecuting attorney's office of the committing county prior to the transfer.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0070, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.05.-560 [71.05.560]. 91-22-044 (Order 3275), § 275-59-071, filed 10/31/91, effective 12/1/91. Statutory Authority: RCW 71.05.560. 88-23-021 (Order 2724), § 275-59-071, filed 11/7/88.]

WAC 388-875-0080 Restoration procedure for a former involuntarily committed person's right to firearm possession. (1) The department and mental health professionals implementing chapter 10.77 RCW shall recognize and affirm that a person is entitled to the immediate restoration of the right to firearm possession, as described under RCW 9.41.040 (6)(c), when the person no longer requires treatment or medication for a condition related to the commitment.

(2) Mental health professionals implementing the provisions of chapter 71.05 RCW shall provide to the court of competent jurisdiction such relevant information concerning the commitment and release from commitment as the court may request in the course of reaching a decision on the restoration of the person's right to firearm possession. (See RCW 9.41.097.)

(3) A person who has been barred from firearm possession under RCW 9.41.040(6) and who wishes to exercise this right, may petition the court which ordered involuntary treatment or, the superior court of the county in which the person resides for restoration of the right to possess firearms. At a minimum, such petition shall include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the order of final discharge entered by the committing court.

(4) A petitioner shall show that the petitioner no longer requires treatment or medication for a condition related to the commitment.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0080, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 9.41.-040(6). 94-06-025 (Order 3709), § 275-59-072, filed 2/23/94, effective 3/26/94.]

WAC 388-875-0090 Conditional release. (1) Any person committed to the secretary as criminally insane may make application to the secretary for conditional release.

(2) The secretary designates the superintendent of the treatment facility, if no superintendent, then the director of the division, as the person to receive and act on such application for conditional release.

(3) The person making application for conditional release shall not, under any circumstances, be released until there is a court hearing on the application and recommendations and a court order authorizing conditional release has been issued.

(4) If conditional release is denied by the court the person making the applications may reapply after a period of six months from the date of denial.

(5) If the court grants conditional release and places the person making application under the supervision of a department employee, that supervising department employee shall make monthly reports, unless indicated otherwise by the court, concerning the conditionally released person's progress and compliance with the terms and conditions of conditional release. Such reports shall be forwarded to the committing court, the division, the prosecuting attorney, and the treatment facility in which the person was most recently housed.

(6) The following persons are designated to exercise power and authority of the secretary contained in RCW 10.77.190:

(a) The director or designee of the division;

(b) The probation and parole office, if any, supervising the conditionally released person; and

(c) The treatment facility supervising the conditionally released person or from which the person was conditionally released.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0090, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.-090. 79-03-038 (Order 1373), § 275-59-080, filed 3/1/79; Order 846, § 275-59-080, filed 8/9/73.]

WAC 388-875-0100 Retroactivity. (1) This chapter shall apply to persons committed to the secretary or the department, under prior rules and regulations, as incompetent to stand trial or as being criminally insane and therefore requires that these individuals be provided:

(a) An individualized treatment plan;

(b) An evaluation to be forwarded to the committing court;

(c) Applicability of time limitations and requirements provided herein;

(d) A maximum release date; and

(e) An opportunity to apply for conditional release.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0100, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-090, filed 8/9/73.]

WAC 388-875-0110 Access to records by criminal justice agencies. Upon written request, criminal justice agencies shall have access to the following documents developed

pursuant to the procedures set forth in chapter 10.77 RCW. the most recent forensic:

(1) Psychiatric assessment;

(2) Release summary; and

(3) Pre-trial report of the examination, either inpatient or outpatient.

Other relevant information may be provided by agreement between the requesting criminal justice agency and the treatment facility, subject to federal and state confidentiality provisions.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, § 388-875-0110, filed 12/6/00, effective 1/6/01.]

Chapter 388-880 WAC

SPECIAL COMMITMENT—SEXUALLY VIOLENT PREDATORS

(Formerly chapter 275-155 WAC)

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-880-032 Recommendation for release to a less restrictive alternative (LRA). [Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-032, filed 12/27/01, effective 1/27/02.] Repealed by 03-23-022, filed 11/10/03, effective 12/11/03. Statutory Authority: RCW 71.09.040(4).

WAC 388-880-005 Special commitment of sexually violent predators—Legal basis. (1) Chapter 71.09 RCW authorizes the department to develop a sexual predator program (SPP) for a person the court determines to be a sexually violent predator.

(2) The department's SPP shall provide:

(a) Custody, supervision, and evaluation of a person court-detained to the SPP to determine if the person meets the definition of a sexually violent predator under chapter 71.09 RCW; and

(b) Treatment, care, evaluation and control of a person court-committed as a sexually violent predator.

(3) Evaluations and evaluation procedures may be established in coordination with the department, the department of corrections and the end of sentence review committee.

(4) Secure facilities operated by the department for the sexual predator program include the special commitment center (SCC) total confinement facility, the secure community transition facility, and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

(5) The secretary or designee may execute such agreements as appropriate and necessary to implement this chapter.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-005, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-005, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-005, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-005, filed 8/21/90, effective 9/21/90.]

WAC 388-880-007 Purpose. These rules carry out the legislative intent of chapter 71.09 RCW, authorizing the department to provide evaluation, care, control, and treatment of persons court-detained or court-committed to the sexual predator program.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-007, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-007, filed 12/27/01, effective 1/27/02.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Appropriate facility" means the total confinement facility the department uses to hold and evaluate a person court-detained under chapter 71.09 RCW.

"Care" means a service the department provides during a person's detention or commitment within a secure facility toward adequate health, shelter, and physical sustenance.

"Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a period of custody under chapter 71.09 RCW.

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

"Escorted leave" means a leave of absence from a facility housing persons court-detained or court-committed under chapter 71.09 RCW under the continuous supervision of an escort.

"Evaluation" means an examination, report, or recommendation by a professionally qualified person to determine if a person has a personality disorder and/or mental abnormality which renders the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"Immediate family" includes a resident's parents, stepparents, parent surrogates, legal guardians, grandparents, spouse, brothers, sisters, half or stepbrothers or sisters, children, stepchildren, and other dependents.

"Indigent" means a resident who has not been credited with twenty-five dollars or more total from any source for

deposit to the resident's trust fund account during the thirty days preceding the request for an escorted leave and has less than a twenty-five dollar balance in his/her trust fund account on the day the escorted leave is requested, and together with his/her requesting immediate family member affirm in writing that they cannot afford to pay the costs of the escorted leave without undue hardship. A declaration of indigency shall be signed by the resident and the resident's requesting immediate family member on forms provided by the department.

"Individual treatment plan (ITP)" means an outline the SCC staff persons develop detailing how control, care, and treatment services are provided to a court-committed person or to a court-detained person.

"Less restrictive alternative" means court-ordered treatment in a setting less restrictive than total confinement which satisfies the conditions stated in RCW 71.09.092.

"Less restrictive alternative facility" means a secure community transition facility as defined under RCW 71.09.-020(1).

"Mental abnormality" means a congenital or acquired condition, including a personality disorder, affecting the person's emotional or volitional capacity, predisposing the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.

"Oversight" means official direction, guidance, review, inspection, investigation, and information gathering activities conducted for the purposes of program quality assurance by persons or entities within, or external to, the SCC.

"Personality disorder" carries the same definition as found in the DSM-IV-TR and includes psycopathy as assessed using the Hare PCL-R or similar instrument.

"Predatory" means acts a person directs toward:

(1) Strangers;

(2) Individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or

(3) Persons of casual acquaintance with whom no substantial personal relationship exists.

"Professionally qualified person" means:

(1) **"Psychiatrist"** means a person licensed as a physician in this state, or licensed or certified in another state, in accordance with chapters 18.71 and 18.57 RCW. In addition, the person shall:

(a) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(b) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology.

(2) **"Psychologist"** means a person licensed as a doctor of psychology in this state, or licensed or certified in another state, in accordance with chapter 18.83 RCW;

(3) **"Clinical practitioner"** means a sex offender treatment provider certified by the department of health under chapter 18.155 RCW.

"Resident" means a person court-detained or court-committed pursuant to chapter 71.09 RCW.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Secure community transition facility" means a residential facility for persons civilly committed and conditionally released to a less restrictive alternative under chapter 71.09 RCW. A secure community transition facility has supervision and security, and either provides or ensures the provision of sex offender treatment services. Secure community transition facilities include, but are not limited to, the facilities established in RCW 71.09.201 and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

"Secure facility" means a residential facility for persons court-detained or court-committed under the provisions of chapter 71.09 RCW that includes security measures sufficient to protect the community. Such facilities include total confinement facilities, secure community transition facilities, and any residence used as a court-ordered placement in RCW 71.09.096.

"Sexual predator program" means a department-administered and operated program including the special commitment center (SCC) established for:

(1) A court-detained person's custody and evaluation; or

(2) Control, care, and treatment of a court-committed person defined as a sexually violent predator under chapter 71.09 RCW.

"Sexually violent offense" means an act defined under chapter 9A.28 RCW, RCW 9.94A.030 and 71.09.020.

"Sexually violent predator" means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"Superintendent" means the person delegated by the secretary of the department to be responsible for the general operation, program, and facilities of the SCC.

"Total confinement facility" means a facility that provides supervision and sex offender treatment services in a total confinement setting. Total confinement facilities include the special commitment center and any similar facility designated as a secure facility by the secretary.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-010, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-010, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-010, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-010, filed 8/21/90, effective 9/21/90.]

WAC 388-880-020 Authorization for indefinite commitment to the sexual predator program. A person must be admitted to the custody of the department when, under RCW 71.09.060, a court or jury determines, beyond a reasonable doubt, that the person is a sexually violent predator and commits the person for placement in a secure facility operated by the department for control, care, and treatment.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-020, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-020, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-020, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-020, filed 8/21/90, effective 9/21/90.]

WAC 388-880-030 Sexual predator program initial evaluation. (1) When a court orders a person transferred to an appropriate facility for an evaluation as to whether the person is a sexually violent predator, pursuant to RCW 71.09.040(4), the department shall, prior to the scheduled commitment hearing or trial, provide an evaluation to the court, and must make a recommendation as to whether the person has been convicted of or charged with a crime of sexual violence and suffers from a mental abnormality or personality disorder which makes the person more likely than not to engage in predatory acts of sexual violence if not confined in a secure facility.

(2) The evaluation must be conducted in accordance with the criteria set forth in WAC 388-880-033, and must be in the form required by and filed in accordance with WAC 388-880-034 and 388-880-036.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-030, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-030, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-030, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-030, filed 8/21/90, effective 9/21/90.]

WAC 388-880-031 Sexual predator program annual evaluation. (1) Annually or as required by court order, the department shall conduct an evaluation and examine the mental condition of each person court-committed under chapter 71.09 RCW.

(2) The annual evaluation must include consideration of whether:

(a) The person currently meets the definition of a sexually violent predator; and

(b) Conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

(3) The report of the department shall be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and shall be prepared by a professionally qualified person as defined herein.

(4) The department shall file this periodic report with the court that detained or committed the person under chapter 71.09 RCW.

(5) A copy of this report shall be served on the prosecuting agency involved in the initial hearing or commitment and upon the detained or committed person and his or her counsel.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-031, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-031, filed 12/27/01, effective 1/27/02.]

WAC 388-880-033 Evaluator—Qualifications. Professionally qualified persons under contract to provide evaluative services must:

(1) Have demonstrated expertise in conducting evaluations of sex offenders, including diagnosis and assessment of re-offense risk,

(2) Have demonstrated expertise in providing expert testimony related to sex offenders of other forensic topics, and

(3) Provide documentation of such qualification to the department.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-033, filed 11/10/03, effective 12/11/03.]

WAC 388-880-034 Evaluator—Pretrial evaluation responsibilities. The evaluation done in accordance with WAC 388-880-030(1) in preparation for a trial or hearing must be based on the following:

(1) Examination of the resident, including a forensic interview and a medical examination, if necessary;

(2) Review of the following records, tests or reports relating to the person:

(a) All available criminal records, to include arrests and convictions, and records of institutional custody, including city, county, state and federal jails or institutions, with any records and notes of statements made by the person regarding criminal offenses, whether or not the person was charged with or convicted of the offense;

(b) All necessary and relevant court documents;

(c) Sex offender treatment records and, when permitted by law, substance abuse treatment program records, including group notes, autobiographical notes, progress notes, psycho-social reports and other material relating to the person's participation in treatment;

(d) Psychological and psychiatric testing, diagnosis and treatment, and other clinical examinations, including records of custody in a mental health treatment hospital or other facility;

(e) Medical and physiological testing, including plethysmography and polygraphy;

(f) Any end of sentence review report, with information for all prior commitments upon which the report or reports were made;

(g) All other relevant and necessary records, evaluations, reports and other documents from state or local agencies;

(h) Pertinent contacts with collateral informants;

(i) Other relevant and appropriate tests that are industry standard practices;

(j) All evaluations, treatment plans, examinations, forensic measures, charts, files, reports and other information made for or prepared by the SCC which relate to the resident's care, control, observation, and treatment.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-034, filed 11/10/03, effective 12/11/03.]

WAC 388-880-035 Refusal to participate in pretrial evaluation. If the person refuses to participate in examinations, forensic interviews, psychological testing or any other interviews necessary to conduct the initial evaluation under WAC 388-880-030(1), the evaluator must notify the SCC. The SCC will notify the prosecuting agency for potential court enforcement.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-035, filed 11/10/03, effective 12/11/03.]

WAC 388-880-036 Pretrial evaluation—Reporting. (1) The evaluation must be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and must be prepared by a professionally qualified person.

(2) The report of the evaluation must include:

(a) A description of the nature of the examination;

(b) A diagnosis of the mental condition of the person;

(c) A determination of whether the person suffers from a mental abnormality or personality disorder;

(d) An opinion as to whether the person meets the definition of a sexually violent predator.

(3) The department shall file the evaluation with the court that detained or committed the person under chapter 71.09 RCW.

(4) A copy of the evaluation must be served on the prosecuting agency involved in the initial hearing or commitment, and upon the court-detained or court-committed person and his or her counsel.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-036, filed 11/10/03, effective 12/11/03.]

WAC 388-880-040 Individual treatment. (1) When the court detains a person or commits a person to the SCC, SCC staff persons shall develop an individual treatment plan (ITP) for the person.

(2) The ITP shall be based upon, but not limited to, the following information as may be available:

(a) The person's offense history;

(b) A psycho-social history;

(c) The person's most recent evaluation; and

(d) A statement of high risk factors for potential reoffense, as may be ascertained over time.

(3) The ITP shall include, but not be limited to:

(a) A description of the person's specific treatment needs in:

(i) Sex offender specific treatment;

(ii) Substance abuse treatment;

(iii) Supports to promote psychiatric stability;

(iv) Supports for medical conditions and disability;

(v) Social, family, and life skills.

(b) An outline of intermediate and long-range treatment goals, with cognitive and behavioral measures for achieving the goals;

(c) The treatment strategies for achieving the treatment goals;

(d) A description of SCC staff persons' responsibilities; and

(e) A general plan and criteria, keyed to the resident's achievement of long-range treatment goals, for recommending to the court whether the person should be released to a less restrictive alternative.

(4) SCC staff persons shall review the person's ITP every six months.

(5) A court-detained person's plan may include access to program services and opportunities available to persons who are court-committed, with the exception that the court-detained person may be restricted in employment and other activities, depending on program resources and incentives reserved for persons who are court-committed and/or actively involved in treatment.

(6) Nothing in this chapter shall exclude a court-detained person from engaging in the sex offender treatment program and, should the person elect to engage in treatment prior to the person's commitment trial:

(a) The person shall be accorded privileges and access to program services in a like manner as are accorded to a court-committed person in treatment; and

(b) Shall not, solely by reason of the person's voluntary participation in treatment, be judged nor assumed by staff, administrators or professional persons of the SCC or of the department to meet the definition of a sexually violent predator under chapter 71.09 RCW.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-040, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-040, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-040, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-040, filed 8/21/90, effective 9/21/90.]

WAC 388-880-042 Resident records—Purposes. (1) The SCC shall maintain records for each person court-detained for evaluation or court-committed for treatment as a sexually violent predator. Such records shall include:

(a) All evaluations, records, reports, and other documents obtained from other agencies relating to the person prior to the person's detention and/or commitment to the SCC;

(b) All evaluations, clinical examinations, forensic measures, charts, files, reports, and other information made for or prepared by SCC personnel, contracted professionals, or others which relate to the person's care, control, and treatment during the person's detention or commitment to, the SCC.

(2) Records made by contracted professional persons providing treatment or residential services may be maintained in their professional files, subject to contractual arrangement for SCC or department access to those records.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-042, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-042, filed 12/27/01, effective 1/27/02.]

WAC 388-880-043 Resident clinical records—Location and custody. (1) Records pertaining to residents of the SCC shall be kept in a location accessible only to assigned treatment providers and authorized staff persons.

(2) During the period of a person's residence at the SCC secure facility or LRA facility:

(a) The person's treatment records shall be maintained in the facility wherein the resident is housed.

(b) The person's medical and psychiatric records shall be maintained in the facility wherein the resident is housed and directly available to medical and emergency treatment providers and authorized staff persons.

(3) During the period of a person's residence in a less restrictive alternative facility operated by the department, the person's treatment records shall be maintained in a safe location accessible only by authorized staff.

(4) During a period of a resident's less restrictive alternative placement in a private home or in a facility operated by a contracting agency:

(a) Original behavioral and treatment records and evaluations shall be maintained by the contracted professional person providing treatment and copies thereof shall be made available to the SCC or the department by contract requirement; and

(b) Copies of documents held by the SCC may be made available as necessary to the contracting agency, the contracted treatment provider, and the assigned community corrections officer.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-043, filed 12/27/01, effective 1/27/02.]

WAC 388-880-044 Resident records—Access. (1) Upon request and proper showing, the department shall provide to the following persons access to a court-detained or court-committed person for an evaluation and access to all records and reports related to the person's detention, commitment, control, care, and treatment:

(a) The person's attorney;

(b) The person's professionally qualified person, if any;

(c) The prosecuting attorney, or the attorney general, if requested by the prosecuting attorney;

(d) The professionally qualified person; and

(e) Any entity, person or agency having lawful access to such records.

(2) Upon documented request by a resident, the SCC shall provide the resident supervised access to all records and reports, or to redacted copies thereof, related to the person's commitment, control, care, and treatment. The SCC may reasonably limit conditions, frequency and duration of the person's access to the person's records and reports.

(3) A policy on access to resident records shall be maintained and published to residents of the SCC.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-044, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-044, filed 12/27/01, effective 1/27/02.]

WAC 388-880-045 Resident records—Retention. (1) The SCC shall create schedules and requirements, consistent with department policy, for the retention, storage, and disposal of records, documents, evaluations, reports, and other material related to SCC residents, to include:

(a) While a person is currently court-detained or court-committed to the SCC;

(b) Following a court ruling that a person does not meet the definition of a sexually violent predator within chapter 71.09 RCW and upon the person's release from the custody of the department;

(c) Following a resident's unconditional discharge from commitment;

(d) Following a resident's death.

(2) All original records specified herein and held by the SCC shall be retained in the SCC total confinement facility for a period of five years, and in the records center of the Secretary of State for a period consistent with department administrative policy, after a resident's:

(a) Release following a court ruling that the person does not meet the definition of a sexually violent predator within chapter 71.09 RCW;

(b) Unconditional discharge from commitment; or

(c) Death.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-045, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-045, filed 12/27/01, effective 1/27/02.]

WAC 388-880-050 Rights of a person court-detained or court-committed to the special commitment center. (1) During a person's period of detention or commitment, the department shall:

(a) Apprise the person of the person's right to an attorney and to retain a professionally qualified person to perform an evaluation on the person's behalf;

(b) Provide access to the person and the person's records in accordance with RCW 71.09.080 and WAC 388-880-044.

(2) A person the court detains for evaluation or commits to the SCC shall:

(a) Receive adequate care and individualized treatment;

(b) Be permitted to wear the person's own clothing except as may be required during an escorted leave from the secure facility, and to keep and use the person's own possessions, except when deprivation of possessions is necessary for the person's protection and safety, the protection and safety of others, or the protection of property within the SCC;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SCC account;

(d) Have access to reasonable personal storage space within SCC limitations;

(e) Be permitted to have approved visitors within reasonable limitations;

(f) Have reasonable access to a telephone to make and receive confidential calls within SCC limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SCC limitations and according to established safeguards against the receipt of contraband material to include, in the resident's presence, opening and inspecting packages and fanning written material; and

(ii) Send written communication regarding the fact of the person's detention or commitment.

(3) A person the court commits to the SCC shall have the following procedural rights to:

(a) Have reasonable access to an attorney and be informed of the name and address of the person's designated attorney;

(b) Petition the court for release from the SCC; and

(c) Receive annual written notice of the person's right to petition the committing court for release. The department's written notice and waiver shall:

(i) Include the option to voluntarily waive the right to petition the committing court for release; and

(ii) Annually be forwarded to the committing court by the department.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-050, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-050, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-050, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-050, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-050, filed 8/21/90, effective 9/21/90.]

WAC 388-880-055 Recommendation for release to a less restrictive alternative (LRA). If the court or jury determines that the person is a sexually violent predator, upon an evaluation which supports a person's unconditional discharge or release to a less restrictive alternative, the secretary or secretary's designee shall authorize the person to petition the court in accordance with RCW 71.09.090.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-055, filed 11/10/03, effective 12/11/03.]

WAC 388-880-060 Sexual predator program reimbursement. (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person court-committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under chapter 275-16 WAC.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-060, filed 11/10/03, effective 12/11/03. 99-21-001, recodified as § 388-880-060, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

WAC 388-880-070 Escorted leave—Purpose. The purpose of WAC 275-155-070 through 275-155-140 is:

(1) To set forth the conditions under which residents will be granted leaves of absence;

(2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and

(3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

WAC 388-880-080 Reasons allowed. An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

(1) Go to the bedside of a member of the resident's immediate family as defined in WAC 275-155-010, who is seriously ill;

(2) Attend the funeral of a member of the resident's immediate family as defined in WAC 275-155-010; and

(3) Receive necessary medical or dental care which is not available in the institution.

[99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

WAC 388-880-090 Conditions. (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

WAC 388-880-100 Application requests and approval for escorted leave. The superintendent, or designee, shall establish a policy and procedures governing the method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

(1) The nature and length of the escorted leave;

(2) The community risk associated with granting the request based on the resident's history of security or escape risk;

(3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;

(4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;

(5) The resident's family's level of involvement and commitment to the escorted leave planning process;

(6) The rehabilitative or treatment benefits which could be gained by the resident; and

(7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

WAC 388-880-110 Escort procedures. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts from the total confinement facility must be employees of either the department of social and health services or the department of corrections and must have attained permanent employee status. At least one of the escorts must be experienced in the escort procedures.

(2) The superintendent, or designee, shall determine the use and type of restraints necessary for each escorted leave on an individual basis.

(3) Escorted leaves supervised by department of corrections staff shall require the approval of the SCC superintendent, or designee, and be done in accordance with applicable department of corrections policy and procedures. The department of corrections shall be reimbursed, according to rates and procedures established between the department of social and health services and the department of corrections. Correctional officers may wear civilian clothing when escorting a resident for a bedside visit or a funeral.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-110, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-110, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.]

WAC 388-880-120 Expenses. (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the merit system rules.

(3) Cost of housing the resident in a city or county jail shall be charged to the resident in accordance with WAC 275-155-130.

[99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

WAC 388-880-130 Expenses—Paid by resident. (1) The expenses of the escorted leave as enumerated in WAC 275-155-120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 275-155-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

WAC 388-880-140 Expenses—Paid by department. The expenses of the escorted leave shall be absorbed by the state if:

(1) The resident and his/her immediate family are indigent as defined in WAC 275-155-010; or

(2) The expenses were incurred to secure medical care.

[99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]

Chapter 388-881 WAC

SEXUAL PREDATOR PROGRAM—EXTERNAL OVERSIGHT

(Formerly chapter 275-155 WAC)

WAC

WAC 388-881-010 External oversight of the special commitment center. Independent external oversight of the SCC shall include:

(1) A governing body;

(2) Professional standards to be used as a benchmark for evaluation;

(3) An inspection of care according to accepted professional standards;

(4) An ombudsman service; and

(5) External investigation of incidents.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-010, filed 12/27/01, effective 1/27/02.]

WAC 388-881-015 External oversight—Governing body. The governing body for the special commitment center shall:

(1) Be appointed by the secretary of the department of social and health services (DSHS);

(2) Derive its membership in accordance with department policy established to this purpose;

(3) Operate under by-laws approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-015, filed 12/27/01, effective 1/27/02.]

WAC 388-881-020 External oversight—Professional standards. (1) The department shall develop and governing body approve for use professional practice standards applicable to treatment programs for civilly committed adult sex offenders.

(2) Such standards shall include provisions requiring:

(a) Staff competency, training, and supervision;

(b) Adequacy of treatment components and measures of progress;

(c) A treatment-supportive environment;

(d) Provision of medical services appropriate to a residential treatment setting; and

(e) Program oversight.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-020, filed 12/27/01, effective 1/27/02.]

WAC 388-881-025 External oversight—Annual inspection of care (IOC). (1) An independent, annual, on-site inspection of care, performed according to professional standards approved under this chapter, shall be conducted of the SCC at least annually.

(2) The purpose of the IOC shall be to provide objective measures of service delivery, for internal program use and quality management, to the governing body.

(3) Members of the inspection of care team shall be contracted by the department annually for a specified period during which they shall:

(a) Conduct an on-site and documentary inspection;

(b) Prepare interim and final, and, as requested by the SCC superintendent or governing body, supplementary reports;

(c) Receive and consider SCC program responses to all reports.

(4) The IOC team shall be of no fewer than four and no more than six persons.

(a) At least one member of the IOC team must not be a DSHS employee; and

(b) At least one member must be a sex offender treatment provider.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-025, filed 12/27/01, effective 1/27/02.]

WAC 388-881-030 External oversight—Ombudsman service. (1) The SCC shall retain an ombudsman service for the purpose of conducting independent, neutral reviews of program conformance with internal SCC policies in the care, control and treatment of residents at the SCC.

(2) The ombudsman function shall be outside the supervision of the superintendent of the SCC and of the assistant secretary for health and rehabilitation services.

(3) In performance of the ombudsman function, the individual(s) so employed shall be afforded access to all records and documents normally available to public inspection according to rules and policies of the department and of the state of Washington.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-030, filed 12/27/01, effective 1/27/02.]

WAC 388-881-035 External oversight—Investigation of incidents. (1) The Washington state patrol shall investigate incidents which involve SCC residents in accordance with department policy.

(2) The scope and authority for such investigations shall be determined through an interagency agreement between the department and the Washington state patrol.

(3) Criteria to determine which incidents justify external investigation shall be approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-035, filed 12/27/01, effective 1/27/02.]

Chapter 388-885 WAC

CIVIL COMMITMENT COST REIMBURSEMENT

(Formerly chapter 275-156 WAC)

WAC

WAC 388-885-005 Purpose. These rules establish the standards and procedures for reimbursing counties for the cost incurred during civil commitment trial, annual evaluation, and review processes and release procedures related to chapter 71.09 RCW.

The department's reimbursement to counties is limited to appropriated funds and is intended to minimize primary or direct costs to counties for proceedings and related to civil commitment of sexually violent predators.

Indirect costs and costs incurred in excess of or different from those allowed by the itemized schedule of reimbursements as described in WAC 388-885-035 are the responsibility of the county.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-005, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.]

WAC 388-885-010 Definitions. (1) "Attorney cost" means the fully documented itemized hourly cost directly related to the violent sexual predator civil commitment process for:

(a) A single assigned prosecuting attorney;

(b) When the person is indigent, a single court-appointed attorney;

(c) Additional counsel, for the defense or prosecution, when additional defense counsel is approved by the trial judge for good cause; and

(d) Paralegal services and other costs, itemized based on a schedule of reimbursements as described in WAC 388-885-035.

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

(3) "Evaluation by expert cost" is as described in WAC 388-885-013.

(4) "Incidental cost" means county-incurred efforts or costs that are not otherwise covered and are exclusively attributable and necessary to the trial of a person alleged to be a "sexually violent predator."

(5) "Investigative cost" means a cost incurred by a police agency or other investigative service in the course of investigating issues specific to:

(a) Filing or responding to a petition alleging a person is a "sexually violent predator;" or

(b) Testifying at a hearing to determine if a person is a "sexually violent predator."

(6) "Medical cost" means a county-incurred extraordinary medical expense beyond the routine services of a jail.

(7) "Secretary" means the secretary of the department of social and health services.

(8) "Transportation cost" means the cost a county incurs when transporting a person alleged to be, or having been found to be, a "sexually violent predator," to and from a sexual predator program facility.

(9) "Trial cost" means the costs a county incurs as the result of filing a petition for the civil commitment of a person alleged to be a "sexually violent predator" under chapter 71.09 RCW. This cost is limited to fees for:

(a) Judges;

(b) Court clerk;

(c) Bailiff services;

(d) Court reporter services;

(e) Transcript typing and preparation;

(f) Expert and nonexpert witnesses;

(g) Jury; and

(h) Jail facilities.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-010, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.]

WAC 388-885-013 Limitations on reimbursement costs related to expert evaluations. (1) "Evaluation by expert cost" means a county-incurred itemized hourly service rate directly resulting from the completion of a comprehensive examination and/or a records review and other costs,

itemized based on the schedule of reimbursements as described in WAC 388-885-035, by a single examiner selected and appointed by the court of a person who is indigent, when:

(a) Investigated for "sexually violent predator" probable cause;

(b) Alleged to be a "sexually violent predator" and who has had a petition filed; or

(c) Committed as a "sexually violent predator" and under review for release.

(2) The department will reimburse a county for costs related to the evaluation of an indigent person by an additional examiner only upon a finding by the superior court that such appointment is for good cause. In making its finding of good cause the superior court shall consider and issue written findings on whether:

(a) Any previous expert(s) appointed to assist the indigent person lack expertise to address a new area of concern;

(b) The request for an additional expert is being requested merely because the opinion of a prior expert was not favorable to respondent's position;

(c) The request is being interposed for the purpose of delaying the proceeding; or

(d) The previously appointed expert is unavailable for testimony at trial.

(3) The department will not reimburse a county for expert evaluation costs under the following circumstances:

(a) Where the appointed expert lacks appropriate qualifications as provided for in WAC 388-880-033; or

(b) For any charges related to international travel by an expert to or from a destination outside of North America, including but not limited to, airfare, meals, hourly rates, and accommodations.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-013, filed 9/11/08, effective 10/12/08.]

WAC 388-885-015 Limitation of funds. The department shall:

(1) Reimburse funds to a county when funds are available;

(2) Limit a county's reimbursement to costs of civil commitment trials or hearings as described under this chapter;

(3) Restrict a county's reimbursement to documented investigation, expert evaluation, attorney, transportation, trial, incidental, and medical costs;

(4) Not pay a county a cost under the rules of this section when said cost is otherwise reimbursable under law;

(5) Pay a county's claim for a trial or hearing occurring during each biennium in the order in which the claim is received, until the department's biennial appropriation is expended.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-015, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-015, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.]

WAC 388-885-020 Maximum allowable reimbursement for civil commitment cost. (1) The department shall reimburse a county for actual costs incurred up to the maximum allowable rate as specified in a biennial reimbursement rate schedule created and maintained by the department and approved by the legislature for reimbursement rates and expenses authorized under this chapter.

(2) The reimbursement schedule shall be developed and reviewed by the department for adequacy each biennium.

(a) In developing the reimbursement schedule, the special commitment center will accept input and comment from the public and counties in the form of written substantive documented evidence that reflects a need to change the reimbursement rates found in WAC 388-885-035.

(b) Substantive evidence may be submitted to the special commitment center during the month of June on even numbered years.

(c) Evidence of need should be sent to: DSHS Special Commitment Center, Attn: Chief Financial Officer, P.O. Box 88450, Steilacoom, WA 98388-0646.

(d) Evidence of need will be compiled and reviewed for reimbursement rate change consideration and budget proposal recommendations.

(3) A revised reimbursement schedule shall be presented for legislative review each biennial year as part of the budget proposal for the special commitment center.

(4) When the reimbursement schedule or the related budget is approved by the legislature:

(a) The reimbursement schedule rates found in WAC 388-885-035 will be updated;

(b) A notice of the revised reimbursement rates will be published by the department and sent to each county sheriff, superior court administrator, public defender and prosecutor's office; and

(c) The reimbursement schedule shall be included in any memorandum of understanding, contract, or other document related to reimbursements under this rule which may be communicated by the special commitment center, or entered into between the special commitment center and the counties.

(5) Included in the reimbursement schedule shall be rates for:

(a) Attorney fees;

(b) Legal assistant/paralegal;

(c) Evaluation by expert costs, reimbursable according to the nature of the work performed;

(d) Trial costs, to include the trial judge, court reporters, bailiff, court clerk, transcript preparation services, and compensation for nonexpert witnesses and jurors;

(e) Investigative services;

(f) Medical costs; and

(g) Jail costs.

(6) Travel costs and per diem shall be reimbursed for investigators, attorneys, judges, legal assistant/paralegal, expert evaluators, nonexpert witnesses, jurors, and transporting staff. Reimbursement rates shall be in accordance with applicable state law and state travel policy.

(7) With the submission of an itemized invoice, attorneys and expert evaluators and expert witnesses may also be reimbursed for reasonable time spent in travel.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-020, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory

Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.]

WAC 388-885-025 Billing procedure. (1) When a county requests the department reimburse a county's cost, the county shall:

(a) Make a claim using the state of Washington invoice voucher, Form A 19 1-A;

(b) Attach to the claim necessary documentation, support, and justification materials (the department may require use of an itemized invoice);

(c) Report expenses billed by the hour in one-quarter hour increments unless smaller increments are provided to the county by the vendor; and

(d) Include the name of the person for whom the costs were incurred and the cause number when it exists.

(2) The department may subject a county's claim documentation to periodic audit at the department's discretion.

(3) Only an authorized administrator, or the county administrator's designee, may submit to the department a request for a county's cost reimbursement.

(4) A county shall submit a reimbursement claim to the department within thirty days of receipt of itemized expenditures for services incurred to assure proper handling of the claim.

(5) When a county submits a reimbursement claim on a state invoice voucher (Form A-19 1-A) sent to the Special Commitment Center, Attn: Business Office, P.O. Box 88450, Steilacoom, WA 98388-0646.

(6) If the department's reimbursement appropriation becomes exhausted before the end of a biennium, a county may continue to make a claim for reimbursement. The department may use the reimbursement claim to justify a request for adequate department funding during future biennia.

(7) Claims for reimbursement of costs associated with the subject of this rule will not be accepted if the span of time between the time the services were rendered and the bill was submitted is greater than twelve months.

(8) When the reimbursement fee schedule in WAC 388-885-035 changes following legislative approval there is a transitional period where bills are being received for services rendered prior to the approved increase to the reimbursement schedule rates, such as, bills received for services rendered shall be paid based on the reimbursement schedule rate that existed at the time services were rendered, not the rate that exists at the time the bill is submitted to SCC.

(9) In submitting bills for reimbursement under this rule, the billing entity agrees to maintain records of their billed services and make those records available for auditing by DSHS, or other state auditing service, for a period of thirty-six months following the submission of the bill.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-025, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-025, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.]

WAC 388-885-030 Exceptions. (1) The secretary may grant exceptions to the rules of this chapter. Exceptions granted by the secretary may not include exceptions to the biennial reimbursement rate schedule which is set by legislative mandate.

(2) Exceptions may be allowed on a case-by-case basis for:

(a) Unanticipated expenditures;

(b) For a rate or cost increase related to a single commitment proceeding; or

(c) For a new type or class of expenditure.

(3) A request for exception may only be made by a county administration or an entity of county government that has been independently elected, not from a sub-agency of a county or contractor to a county. A county seeking an exception from the secretary shall request the exception, in writing, to the secretary, through the chief financial officer of the special commitment center.

(4) The department shall deny a claim which does not follow the rules of this chapter unless the secretary or secretary's designee granted an exception before the claim was filed.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-030, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-030, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-030, filed 10/8/91, effective 11/8/91.]

WAC 388-885-035 Reimbursement rate schedule. When a county submits a reimbursement claim according to this chapter, the claim shall be only for costs incurred as defined in this chapter and for the rates provided in this schedule. This schedule of reimbursement rates is effective as of July 1, 2007.

(1) Attorney per hour rate of eighty-five dollars and sixty-five cents (travel and per diem per state schedule).

(2) Legal assistant/paralegal per hour rate of forty-six dollars (travel and per diem per state schedule).

(3) Investigator per hour rate of forty-six dollars (travel and per diem per state schedule).

(4) Evaluation by expert actual cost (travel and per diem per state schedule).

(5) Judge per hour rate of forty-six dollars and five cents.

(6) Court clerk actual hourly salary.

(7) Bailiff actual hourly salary.

(8) Court reporter per hour rate of twenty dollars and seventy-one cents (transcript preparation per page rate of four dollars and thirteen cents).

(9) Expert witnesses actual cost (travel and per diem per state schedule).

(10) Nonexpert witnesses actual cost (travel and per diem per state schedule).

(11) Juror's actual compensation (travel and per diem per state schedule).

(12) Jail facilities daily rate of thirty dollars.

(13) Incidentals - actual costs based on receipts.

[Statutory Authority: Chapter 71.09 RCW and RCW 72.01.090. 08-19-042, § 388-885-035, filed 9/11/08, effective 10/12/08. 99-21-002, recodified as § 388-885-035, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-035, filed 10/8/91, effective 11/8/91.]

WAC 388-885-040 Audits. The department may audit county reimbursement claims at the department's discretion.

[99-21-002, recodified as § 388-885-040, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.]

Chapter 388-891 WAC

VOCATIONAL REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 388-890 WAC (part))

WAC

PURPOSE

WAC 388-891-0005 What is the purpose of this chapter? This chapter explains the types of vocational rehabilitation services (referred to as **"VR services"** in this chapter) available to individuals who are eligible through the department of social and health services (DSHS), division of vocational rehabilitation (DVR).

VR services are offered to assist individuals with disabilities to prepare for, get, and keep jobs that are consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. This chapter is consistent with the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1998 and codified in 34 Code of Federal Regulations, Parts 361 and 363 and with state laws and DSHS requirements.

[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, § 388-891-0005, filed 12/20/02, effective 2/3/03.]

DEFINITIONS

WAC 388-891-0010 What definitions apply to this chapter? "Competitive employment" means:

(1) Part-time or full-time work;

(2) Work that is performed in an integrated setting;

(3) Work for which an individual is paid at or above the minimum wage; and

(4) Work for which an individual earns the same wages and benefits as other employees doing similar work who are not disabled.

"Employment outcome" means competitive employment, supported employment, self-employment, telecommuting, business ownership, or any other type of employment in an integrated setting that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

"Extended employment" means work in a nonintegrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act.

"Extreme medical risk" means medical conditions that are likely to result in substantial physical or mental impairments or death if services, including mental health services, are not provided quickly.

"Family member" means a person who is your relative or legal guardian; or someone who lives in the same household as you and has a substantial interest in your well being.

"Individual with a disability" means an individual:

(1) Who has a physical or mental impairment;

(2) Whose impairment results in a substantial impediment (medical, psychological, vocational, educational, communication, and others) hindering her or his ability to achieve an employment outcome; and

(3) Who can achieve an employment outcome as a result of receiving VR services.

"Integrated setting" means:

(1) The setting in which you receive a VR service is integrated if it is a setting commonly found in the community (such as a store, office or school) where you come into contact with nondisabled people while you are receiving the service. The nondisabled people you come into contact with are not the same people providing VR services to you.

(2) The setting in which you work is integrated if it is a setting commonly found in the community where you come into contact with nondisabled people as you do your work. The amount of contact you have with nondisabled people is the same as what a nondisabled person in the same type of job would experience.

"Most recent tax year" means the most recent calendar year for which you filed or were required to file an income tax return with the United States Internal Revenue Service (IRS).

"Physical, mental or sensory impairment" means:

(1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculo-skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or

(2) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Representative" means any person chosen by an applicant or eligible individual, including a parent, family member or advocate, unless a representative has been appointed by a court to represent the individual, in which case the court-appointed representative is the individual's representative.

"Substantial impediment to employment" means the limitations you experience as a result of a physical, mental or sensory impairment that hinder your ability to prepare for, find, or keep a job that matches your abilities and capabilities.

[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, § 388-891-0010, filed 12/20/02, effective 2/3/03.]

PROTECTION AND USE OF CONFIDENTIAL INFORMATION

WAC 388-891-0100 What personal information about me does DVR keep on file? DVR keeps a case service record while you are receiving services and for three years after your case is closed. The case service record includes, but is not limited to:

(1) The DVR application form or written request for VR services.

(2) Documentation explaining the need for the trial work experience or extended evaluation, if conducted, and the written plan for conducting the trial work experience or extended evaluation, and documentation of progress reviews.

(3) Documentation and records that support the determination of eligibility or ineligibility.

(4) Documentation supporting the severity of disability and priority category determination.

(5) Financial statement and/or related records.

(6) Plan for employment, amendments to the plan, if amended, and information supporting the decisions documented on the plan.

(7) Documentation describing how you used informed choice to make decisions throughout the process, including assessment services, selection of an employment outcome, VR services, service provider, type of setting and how to get VR services.

(8) If VR services are provided in a setting that is not integrated, documentation of the reason(s) for using a nonintegrated setting;

(9) If you achieve a competitive employment outcome, documentation to show:

(a) Your wages and benefits;

(b) That the job you have is:

(i) Described in your plan for employment;

(ii) Consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and

(iii) In an integrated setting.

(c) That the services provided to you in your plan for employment helped you become employed;

(d) That you have been employed for at least ninety days and that you no longer need vocational rehabilitation services;

(e) That you and your VR counselor agree that your employment is satisfactory and that you are performing well; and

(f) That you have been informed, through appropriate modes of communication about the availability of post-employment services.

(10) If you are referred to another state or federal program for services to prepare for, find or keep a job, documen-

tation of the referral, the reason(s) for the referral, and the name of the program(s) to which you are referred.

(11) Documentation of case closure, including:

(a) Reasons for closing the case service record;

(b) How you were involved in the decision to close the case; and

(c) A copy of the closure letter that explains the reason(s) for case closure and your rights if you disagree with the decision.

(12) Documentation of the results of mediation or fair hearings, if held;

(13) Documentation of annual reviews after your case service record is closed as outlined in WAC 388-891-1330 if:

(a) You choose extended employment in a nonintegrated setting;

(b) You achieve a supported employment outcome in an integrated setting for which you are paid in accordance with section 14(c) of the Fair Labor Standards Act; or

(c) DVR determines you are ineligible because you are too severely disabled to benefit from VR services.

(14) Other documentation that relates to your participation in VR services, including your progress, throughout the VR process.

[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, § 388-891-0100, filed 12/20/02, effective 2/3/03.]

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 authority 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 388-891-0110 What happens if DVR receives information that indicates I have a previous history of behavior involving violent or predatory acts? (1) If a VR counselor receives information or records that reasonably lead the VR counselor to believe you have a previous history of violent or predatory behavior, you must participate in an assessment conducted by a licensed psychiatrist, psychologist, counselor, certified sex offender treatment provider, or other qualified professional prior to developing a plan for employment. The assessment is for the purpose of determining the level of risk you present to yourself or others in an employment situation.

(2) The VR counselor must consider the results and recommendations of the assessment in developing the plan for employment, including any restrictions relating to employment outcome or employment setting.

(3) If the results of the assessment indicate a potential risk to a service provider or employer, the individual must consent to release information about the behavior to a potential service provider or potential employer prior to referral for services.

[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, § 388-891-0110, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0120 Can I ask DVR to change incorrect information in my case service record? You may ask DVR to correct information in your case service record that you believe is incorrect. DVR corrects the information, unless DVR disagrees that the information is incorrect. If there is a disagreement about the accuracy of the information, you may provide a written document explaining the information you believe incorrect. DVR puts the document in your case service record.

[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, § 388-891-0120, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0130 Can DVR share personal information in my record with others? (1) DVR shares personal information with others only if:

(a) Another organization or program involved in your VR services needs the information to serve you effectively;

(b) You request information in the case service record be shared with another organization for its program purposes;

(c) You select an employment outcome in a field that customarily requires a criminal history background check as a condition of employment; and

(d) You sign a written consent giving DVR permission to release, exchange, or obtain the information.

(2) DVR may release personal information without your written consent only under the following conditions:

(a) If required by federal or state law;

(b) To a law enforcement agency to investigate criminal acts, unless prohibited by federal or state law;

(c) If given an order signed by a judge, magistrate, or authorized court official;

(d) If DVR reasonably believes you are a danger to yourself or others;

(e) To the DSHS division of child support; or

(f) To an organization, agency or person(s) conducting an audit, evaluation or research.

[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, § 388-891-0130, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0135 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? (1) DVR uses special protections when you share personal information about drug or alcohol abuse or about HIV/AIDS and sexually transmitted diseases.

(2) DVR asks for your specific permission to copy information of this nature before sharing it with a service provider or organization that is helping you reach your employment goals.

(3) Information about drug and alcohol abuse must be handled in accordance with RCW 70.96A.150 and applicable federal and state laws and regulations.

(4) Information about HIV/AIDS or other sexually transmitted diseases must be handled in accordance with RCW 70.24.105 and applicable federal and state laws and regulations.

[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, § 388-891-0135, filed 12/20/02, effective 2/3/03.]

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 388-891-0150 How does DVR protect personal information that is released for audit, evaluation or research? DVR may release personal information for audit, evaluation or research if the results would improve the quality of life or VR services for people with disabilities. Before any personal information is shared, the organization, agency, or individual must agree to the following conditions:

(1) The information must only be used by people directly involved in the audit, evaluation or research;

(2) The information must only be used for the reasons approved by DVR in advance;

(3) The information must be kept secure and confidential;

(4) The information must not be shared with any other parties, including you or your representative; and

(5) The final product or report must not contain any personal information that would identify you without your written consent.

[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, § 388-891-0150, filed 12/20/02, effective 2/3/03.]

CUSTOMER RIGHTS

WAC 388-891-0200 Can a guardian or another representative act on my behalf with DVR? (1) You may select someone to act as your representative, as appropriate, during the VR program.

(2) If you have a legal guardian or a court-appointed representative, he or she must act as your representative.

(a) A legal guardian or court-appointed representative must provide DVR with documentation of guardianship.

(b) Your legal guardian or court-appointed representative must sign the application and other documents that require your signature.

[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, § 388-891-0200, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0205 How do I ask for an exception to a rule in this chapter? (1) A request for exception to a rule in this chapter is submitted to the DVR director or designee in writing, and must include:

(a) A description of the exception being requested;

(b) The reason you are asking for the exception; and

(c) The duration of the exception, if applicable.

(2) An exception requesting a medical service that is otherwise not provided by DVR may only be requested on a trial basis or for a short duration to be specified in the request.

[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, § 388-891-0205, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0210 What happens after I submit a request for an exception? (1) After receiving your request for an exception, the DVR director or designee decides whether to approve the request based on:

(a) The impact of the exception on accountability, efficiency, choice, satisfaction, and quality of services;

(b) The degree to which your request varies from the WAC; and

(c) Whether the rule or condition is a federal regulation that cannot be waived.

(2) The DVR director or designee responds to the request for an exception within ten working days of receiving the request.

(a) If the request is approved, the DVR director or designee provides a written approval that includes:

(i) The specific WAC for which an exception is approved;

(ii) Any conditions of approval; and

(iii) Duration of the exception.

(b) If the request is denied, the DVR director or designee will provide a written explanation of the reasons for the denial.

[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, § 388-891-0210, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0215 What if a DVR counselor makes a decision about my VR services that I don't agree with? (1) If a DVR counselor makes a decision that affects the VR services provided to you that you don't agree with, you may try to resolve the disagreement by any one of the following or a combination of the following:

(a) Seek assistance from the client assistance program, talk to the VR counselor, talk to the VR supervisor, or talk to the DVR director or his or her designee;

(b) Request mediation; and/or

(c) Request a fair hearing.

(2) You may request a fair hearing and/or mediation while you continue to work with the DVR counselor, VR supervisor or DVR director or designee to resolve the disagreement. If you reach agreement prior to the date of the scheduled mediation or fair hearing, the request may be withdrawn.

[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, § 388-891-0215, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0220 What is the client assistance program (CAP)? The client assistance program (CAP) is a program independent of DVR that offers information and advocacy about your rights as a DVR customer and offers assistance to help you receive services. You may ask for help or information from CAP at any time during the rehabilitation process by asking a DVR staff person for information about how to contact CAP or by calling CAP toll free at 1-800-544-2121 voice/TTY. A CAP representative may represent you with DVR if a disagreement occurs that you cannot resolve on your own. CAP attempts to resolve disagreements informally through discussions with the DVR employee(s) involved as a first step. If informal efforts are not successful, CAP may represent you in mediation and/or a fair hearing. CAP services are available at no cost to you.

[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, § 388-891-0220, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0225 What is mediation? (1) Mediation is a process in which a trained mediator conducts a meeting with you and a representative from DVR, usually your DVR counselor to help you settle a disagreement.

(a) The mediator does not work for DVR.

(b) The mediator does not make decisions about your case.

(c) Mediation is voluntary for all parties.

(2) During mediation:

(a) Each party presents information or evidence;

(b) The mediator reviews and explains the laws that apply; and

(c) The mediator helps you and the VR representative reach an agreement, if possible.

(3) You may ask someone to represent you during the mediation, including a CAP representative, however, you must be present.

(4) Agreements you and DVR reach through mediation are not legally binding.

[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, § 388-891-0225, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0230 When can I ask for mediation? You may ask for mediation any time you disagree with a decision DVR makes that affects the VR services that DVR provides to you. Mediation is not used to deny or delay your right to a fair hearing. You may request both mediation and a fair hearing at the same time. If an agreement is reached during mediation, the fair hearing is cancelled.

[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, § 388-891-0230, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0235 Who arranges and pays for mediation? DVR schedules mediation in a timely manner at a location that is convenient to all parties. DVR pays for costs related to mediation, except costs related to a representative or attorney you ask to attend. DVR may pay for VR services you require to participate in mediation, such as transportation or child care.

[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, § 388-891-0235, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0240 Is information discussed during mediation confidential? Discussions during mediation are confidential and may not be used in a later fair hearing or civil proceeding, if one is held. Before beginning a mediation session, all parties must sign a statement of confidentiality.

[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, § 388-891-0240, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0245 If the mediation session results in an agreement, do I receive a written statement of the results? If you and the DVR representative reach an agreement during mediation:

(1) The agreement is documented in writing;

(2) You and the DVR representative sign the written agreement; and

(3) DVR provides you with a copy of the agreement.

[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, § 388-891-0245, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0250 What is a fair hearing? A fair hearing is a review process outlined under the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC that is conducted by an administrative law judge who works for the office of administrative hearings. During a fair hearing, both you and DVR may present information, witnesses, and/or documents to support your position. You may ask someone to represent you, such as an attorney, a friend, a relative, a representative from the client assistance program, or someone else you choose. The administrative law judge makes a decision after hearing all of the information presented; reviewing any documents submitted, and reviewing relevant laws and regulations.

[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, § 388-891-0250, 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:

(a) Your name, address, and telephone number;

(b) The name of the DSHS program that the fair hearing involves (such as DVR);

(c) A written statement describing the decision and the reasons you disagree; and

(d) 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 388-891-0260 After I submit a request for a fair hearing, when is it held? The office of administrative hearings holds a fair hearing within sixty days of receipt of your written request for a hearing, unless you or DVR ask for a later hearing date and the office of administrative hearings determines there is a reasonable cause for the delay.

[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, § 388-891-0260, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0265 What is a prehearing meeting? After you submit a request for a fair hearing, DVR offers you a prehearing meeting. The prehearing meeting can be conducted in person, by telephone, or by another method agreeable to all parties. The purpose of the prehearing meeting is to:

(1) Clarify the decision with which you disagree;

(2) Exchange copies of laws, rules or other information to be presented in the fair hearing;

(3) Explain how the fair hearing is conducted; and

(4) Settle the disagreement, if possible.

[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, § 388-891-0265, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0270 Do I receive a written fair hearing decision? The office of administrative hearings sends you a written report of the findings and decision within thirty days of the fair hearing.

[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, § 388-891-0270, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0275 Is the fair hearing decision final? (1) The office of administrative hearings decision is final and DVR must implement the decision.

(2) If you do not agree with the office of administrative hearings decision, you may pursue civil action through superior court to review that decision.

[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, § 388-891-0275, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0295 Can DVR suspend, reduce or terminate my services if I request a fair hearing? DVR may not suspend, reduce, or terminate agreed upon services if you have requested a fair hearing, unless DVR provides evidence that you provided false information, committed fraud or other criminal acts involving VR services.

[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, § 388-891-0295, filed 12/20/02, effective 2/3/03.]

PAYING FOR VR SERVICES

WAC 388-891-0300 Under what conditions does DVR provide and/or pay for vocational rehabilitation services to individuals? DVR provides and pays for VR services if:

(1) You have completed the application requirements;

(2) You have provided documents that verify your identity and legal work status;

(3) DVR authorizes the services before the services begin;

(4) The services are needed to:

(a) Determine your eligibility for services;

(b) Identify your vocational rehabilitation needs; and/or

(c) Help you get and/or keep a job.

(5) The services to be provided, except services listed in WAC 388-891-0310, are not provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits;

(6) You have completed the financial statement, if required, and have agreed upon what portion, if any, you are required to for your VR services; and

(7) The service provider meets all federal, state, and agency requirements for approval as a DVR service provider.

[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, § 388-891-0300, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0310 What VR services are provided without determining whether services or benefits are available from another program or organization? DVR is not required to determine whether the following services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits:

(1) Assessment services to determine eligibility and/or VR needs;

(2) Counseling and guidance, including information and referral;

(3) Independent living services and evaluations provided by DVR staff;

(4) Job placement and job retention services;

(5) Rehabilitation technology services;

(6) Post-employment services when providing the services listed in subsection (1) through (5) above.

[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, § 388-891-0310, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0320 What if looking for services and benefits available from another program would delay or interrupt my progress toward achieving an employment outcome? (1) A DVR counselor may begin providing VR services without conducting a review to determine whether services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits if the review would delay or interrupt:

(a) VR services to an individual determined to be at extreme medical risk, based on medical evidence provided by a qualified professional;

(b) An immediate job placement; or

(c) Your progress toward achieving the employment outcome identified on your individual plan for employment.

(2) If you receive VR services before services or benefits are available from another program, you begin using the services and benefits from the other program when they become available.

[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, § 388-891-0320, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0325 Does DVR pay for a VR service if services and benefits are available from another program or organization, but I don't want to use them? Except for the services outlined in WAC 388-891-0310, DVR does not pay for services or benefits that can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits. If you choose not to apply for and use the services or benefits, you are responsible for the cost of the services.

[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, § 388-891-0325, 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 388-891-0340 How does DVR determine whether I must pay part of my VR services using my own financial resources? (1) To determine whether you are required to pay a portion of VR services using your own financial resources:

(a) You must complete a DVR financial statement to document your financial status, except for the services outlined in WAC 388-891-0365;

(b) You must provide copies of financial records requested by DVR to establish your financial status.

(2) Depending on your income tax filing status for the most recent tax year, you must provide financial information based on your own individual resources or based on your family resources.

(a) If your income tax status was reported as married filing jointly, married filing separately, or you were listed as a dependent of another person, complete the financial statement based on family resources.

(b) If your income tax status was reported as single, complete the financial statement based on your own financial resources.

(3) If you fail to report your financial status accurately or fail to provide the required information, DVR may deny or suspend services at any time in the rehabilitation process, except the services listed under WAC 388-891-0365.

[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, § 388-891-0340, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0345 Do I have to pay a portion of my VR services if I receive assistance or income support from another public program? If you provide verification that you receive benefits from one of the following programs, you are not required to pay any portion of your VR services.

(1) Department of social and health services (DSHS) income assistance;

(2) Medicaid; or

(3) Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

[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, § 388-891-0345, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0350 What financial information does DVR use to decide if I need to help pay for VR services? (1) You complete a DVR financial statement to disclose the following information used to determine whether you must pay any part of the cost of VR services:

(a) Income from all sources, assets, including but not limited to bank accounts, vehicles, personal property, stocks, bonds, and trusts; and

(b) Living expenses, including household expenses, credit or loan payments, disability-related expenses and other financial obligations.

(2) If the results of the financial statement show that you do not have resources available to help pay for your VR services, DVR provides the services at no cost to you.

(3) If you decline to complete the financial statement or decline to contribute to the cost of VR services, DVR provides only those services listed under WAC 388-891-0365.

[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, § 388-891-0350, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0355 How is the amount I pay for VR services determined? After completing the financial statement, you and a DVR counselor agree how to use the resources identified on the financial statement to help pay for VR services. The costs you agree to pay are documented on the individualized plan for employment (IPE). If your financial status changes, you are required to report the changes to your DVR counselor.

[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, § 388-891-0355, 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 388-891-0365 What VR program services am I not required to help pay for? You are not required to pay any portion of the following VR services, regardless of your financial status:

(1) Assessment services to determine eligibility or VR needs, including independent living evaluations;

(2) Counseling and guidance services provided by DVR staff;

(3) Information and referral services;

(4) Interpreter and reader services;

(5) Personal assistance services;

(6) Job placement;

(7) Job retention services;

(8) Independent living services provided directly by DVR staff; and

(9) Post-employment services that include any of the services in subsections (1) through (8) above.

[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, § 388-891-0365, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0370 Can I select the services and service provider of my choice? (1) You may select VR services that you need to achieve an employment outcome that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) You may select the service provider of your choice if the service provider meets the following conditions:

(a) DVR pays for services that meet your needs at the least cost possible.

(i) If two or more service providers or programs offer comparable services but differ in cost, and you choose the higher cost service or program, you are responsible for those costs in excess of the lower cost service. You can use resources other than DVR funds to pay the remaining cost.

(ii) DVR may pay for a service or program at a higher cost than another service or program if the costs are reasonably comparable.

(b) The service provider meets all federal, state, and DVR requirements for DVR approval.

[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, § 388-891-0370, filed 12/20/02, effective 2/3/03.]

INFORMED CHOICE

WAC 388-891-0400 What is informed choice? Informed choice is the process by which an individual receiving services from DVR makes decisions about VR goals and the VR services and service providers necessary to reach those goals. The decision-making process takes into account the individual's values, lifestyle, and characteristics, the availability of resources and alternatives, and general economic conditions. Informed choice involves communicating clearly with an individual receiving VR services to assure the individual understands and uses pertinent information in the decision making process. The intent of informed choice is to ensure VR services are provided in a manner that promotes respect for individual dignity, personal responsibility, self-determination, and the pursuit of meaningful careers.

[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, § 388-891-0400, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0410 How does DVR support the informed choice process? DVR supports the informed choice process by providing counseling and guidance, information and support to help you make choices that match your strengths, resources, priorities, concerns, abilities, capabilities, and interests, including:

(1) Explaining what choices you can make throughout the rehabilitation process;

(2) Assisting you to identify and get the information you need to explore the options available; and

(3) Helping you understand and evaluate the options.

[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, § 388-891-0410, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0420 What if I don't know how to use the informed choice decision making process? DVR explains how to use informed choice to make decisions about VR goals and services. If it is difficult for you to make informed choices, DVR can help you understand the options available and choose the one that meets your needs.

[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, § 388-891-0420, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0430 What decisions can I make using informed choice? You have the right to make informed choices about VR goals and services throughout the rehabilitation process, including but not limited to:

(1) What assessment services and/or service provider(s) you will use to get the information necessary for DVR to determine eligibility and/or identify your VR needs;

(2) What to include on your individualized plan for employment (IPE), including:

(a) Type of employment outcome and setting;

(b) VR services needed to achieve the employment outcome;

(c) Service provider(s) that will provide the service and setting in which to receive the services; and

(d) Method(s) of arranging and paying for services, from the methods available to DVR under state law and agency policy.

[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, § 388-891-0430, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0440 What information and assistance will DVR provide to help me make informed choices about VR services and service providers? To help you select the VR services you need to achieve an employment outcome and the service provider(s) to use, DVR will help you get the following information, to the extent the information is available and/or appropriate:

(1) Cost, accessibility, and duration of services;

(2) Consumer satisfaction with those services;

(3) Qualifications of potential service providers;

(4) Type(s) of services offered by each service provider;

(5) Type of setting in which the services are provided, including whether the setting is integrated or nonintegrated; and

(6) Outcomes achieved by others served by the service provider.

[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, § 388-891-0440, filed 12/20/02, effective 2/3/03.]

ORDER OF SELECTION

WAC 388-891-0500 What happens if DVR cannot serve every eligible person? If DVR cannot serve all eligible individuals, because there are not enough funds or other resources, DVR must:

(1) Establish a statewide waiting list for services;

(2) Implement a process called order of selection that establishes the order in which DVR selects eligible individuals from the waiting list to begin receiving VR services; and

(3) Provide you with information and guidance (which may include counseling and referral for job placement) about other federal or state programs that offer services to help you meet your employment needs, if available.

[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, § 388-891-0500, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0510 How are individuals selected for services when DVR is operating under an order of selection? When DVR is operating under an order of selection, individuals are selected for services as follows:

(1) At the time you are determined eligible for VR services, a DVR counselor establishes a priority for services category based on the severity of your disability.

(2) As resources become available for DVR to serve additional individuals, DVR selects names from the waiting list in the priority category being served at that time.

(3) The priority categories include:

(a) Priority category 1—Individuals with most severe disabilities;

(b) Priority category 2—Individuals with severe disabilities; and

(c) Priority category 3—Individuals with disabilities.

(4) Within a priority category, the date you applied for VR services determines the order in which you are selected from the waiting list.

[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, § 388-891-0510, 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.]

VR SERVICES

WAC 388-891-0600 What vocational rehabilitation services are available to individuals from DVR? The following VR services are available to individuals from DVR:

(1) Assessment services;

(2) Independent living evaluation and services;

(3) Information and referral services;

(4) Interpreter services;

(5) Job placement services;

(6) Job retention services;

(7) Maintenance services;

(8) Occupational licenses;

(9) Personal assistance services;

(10) Physical and mental restoration services;

(11) Rehabilitation technology services;

(12) Self-employment services;

(13) Services to family members;

(14) Substantial counseling and guidance services;

(15) Tools, equipment, initial stocks and supplies;

(16) Training services;

(17) Transition services;

(18) Translation services;

(19) Transportation services;

(20) Other services; and

(21) Post-employment services.

[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, § 388-891-0600, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0605 What are assessment services? Assessment services, including services provided in a trial work experience or extended evaluation, are provided to obtain information necessary to determine:

(1) Whether you are eligible for VR services;

(2) Severity of disability and priority category; and/or

(3) The employment outcome and VR services to be included in an individualized plan for employment.

[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, § 388-891-0605, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0610 What are independent living services and/or evaluation? Independent living services and/or evaluation includes services provided to:

(1) Identify issues that present problems for you in achieving an employment outcome and services you need to address the issues.

(2) Help you manage the services you need to live independently, get information about benefits available to you and about your rights and responsibilities.

(3) Help you set personal goals, make decisions about life issues and employment, and help your family with issues related to your disability and independence.

(4) Help you manage and balance your life in areas such as budgeting, meal preparation and nutrition, shopping, hygiene, time management, recreation, community resources, and attendant management.

(5) Find out about housing resources and the qualifications, make decisions about the living arrangements and about changing to a more independent living arrangement.

[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, § 388-891-0610, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0615 What are information and referral services? Information and referral services include information and guidance provided to help you explore employment services or benefits available to you from other programs, including other programs within the workforce development system.

[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, § 388-891-0615, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0620 What are interpreter services? Interpreter services include sign language or oral interpretation services for individuals who are deaf or hard of hearing, and tactile interpretation services for individuals who are deaf-blind.

[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, § 388-891-0620, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0625 What are job placement services? Job placement means referral to a specific job that results in a job placement.

[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, § 388-891-0625, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0630 What are job retention services? Job retention means services provided after you have been placed in a job to help you achieve satisfactory performance and keep the job.

[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, § 388-891-0630, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0635 What are maintenance services? Maintenance includes monetary support for expenses such as food, shelter, or clothing that are in excess of your usual living expenses that you need to participate in another VR service. The following examples include, but are not limited to, the ways maintenance may be used:

(1) A uniform or other suitable clothing required to look for or get a job;

(2) Short-term lodging and meals required to participate in assessment or training services not within commuting distance of your home; and

(3) A security deposit or utility hook-ups on housing you need to relocate for a job.

[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, § 388-891-0635, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0640 What are occupational licenses? Occupational licenses are licenses, permits, certificates or bonds showing you meet certain standards or have accomplished certain achievements and/or have paid dues, fees or otherwise qualify to engage in a business, a specific occupation or trade, or other work.

[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, § 388-891-0640, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0645 What are personal assistance services? (1) Personal assistance services include a range of services provided by at least one person to help you perform daily living activities on or off the job that you would perform without assistance if you did not have a disability. Examples include, but are not limited to:

(a) Reader services for individuals who cannot read print because of blindness or other disability. In addition to reading aloud, reader services include transcription of printed information into Braille or sound recordings. Reader services are generally for people who are blind, but may also include individuals unable to read because of serious neurological disor-

ders, specific learning disabilities, or other physical or mental impairments.

(b) Personal attendant services are personal services that an attendant performs for an individual with a disability, including, but not limited to, bathing, feeding, dressing, providing mobility and transportation.

(2) Personal assistance services are only provided in connection with one or more other VR services.

[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, § 388-891-0645, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0650 What are physical and mental restoration services? (1) Physical and mental restoration services are used to diagnose and treat physical and mental impairments.

(2) DVR provides physical and mental restoration services if your disabling condition is stable or slowly progressive and the service is expected to substantially modify, correct, or improve a physical or mental impairment that is a substantial impediment to employment for you within a reasonable length of time and financial support is not readily available from another source, such as health insurance.

(3) Physical and mental restoration services include:

(a) Corrective surgery or therapy;

(b) Diagnosis and treatment of mental or emotional disorders by qualified personnel who meet state licensing requirements;

(c) Dental treatment if the treatment is directly related to an employment outcome, or in emergency situations involving pain, acute infections, or injury;

(d) Nursing services;

(e) Hospitalization (in-patient or outpatient) in connection with surgery or treatment and clinic services;

(f) Drugs and supplies;

(g) Prosthetic and orthotic devices;

(h) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids;

(i) Podiatry;

(j) Physical therapy;

(k) Occupational therapy;

(l) Speech or hearing therapy;

(m) Mental health services;

(n) Treatment of acute or chronic medical conditions and emergencies that result from providing physical and mental restoration services, or that are related to the condition being treated;

(o) Special services for the treatment of end-stage renal disease; and

(p) Other medical or medically related rehabilitation services.

[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, § 388-891-0650, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0655 What are the medical treatments DVR does not pay for? DVR does not pay for the following medical treatments:

(1) Maintenance of your general health or fitness, including, but not limited to, vitamins, in-patient hospital based weight loss programs or for-profit weight loss programs, exercise programs, health spas, swim programs and athletic fitness clubs;

(2) Cosmetic procedures, such as facelifts, liposuction, cellulite removal;

(3) Maternity care;

(4) Hysterectomies, elective abortions, sterilization, and contraceptive services as independent procedures;

(5) Drugs not approved by the Federal Drug Administration for general use or by state law;

(6) Life support systems, services, and hospice care;

(7) Transgender services including surgery and medication management;

(8) Homeopathic and herbalist services, Christian Science practitioners or theological healers; and

(9) Treatment that is experimental, obsolete, investigational, or otherwise not established as effective medical treatment.

[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, § 388-891-0655, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0660 What is rehabilitation technology? Rehabilitation technology includes the use of technology, engineering methods and sciences to design, develop, test, evaluate, apply and distribute technology to address problems faced by individuals with disabilities in functional areas such as mobility, communication, hearing, vision and cognition. Rehabilitation technology includes:

(1) Assistive technology devices, equipment, or products used to increase, maintain, or improve the functional capabilities of an individual with a disability including, but not limited to:

(a) Telecommunications devices;

(b) Sensory aids and devices, including hearing aids, telephone amplifiers and other hearing devices, captioned videos, taped text, Brailled and large print materials, electronic formats, graphics, simple language materials, and other special visual aids;

(c) Vehicle modifications; and

(d) Computer and computer-related hardware and software that is provided to address a disability-related limitation.

(2) Services that assist you in the selection, acquisition, or use of an assistive technology device, including services to:

(a) Evaluate your needs in performing activities in your daily environment;

(b) Select, design, fit, customize, adapt, apply, maintain, repair, or replace an assistive technology device;

(c) Coordinate and use other therapies or services with assistive technology devices, such as education and rehabilitation plans and programs;

(d) Train or give technical assistance to professionals, employers, family members or others who provide services to you, hire you, or are involved in your major life activities.

(3) Real time captioning services;

(4) A written policy, plan, guarantee or warranty (initial or extended) that covers the cost to repair or replace an assistive technology device, a piece of equipment, or another assistive technology product if it is lost or damaged.

[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, § 388-891-0660, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0665 Under what conditions does DVR provide vehicle modifications as a rehabilitation technology service? DVR provides vehicle modifications under the following conditions:

(1) DVR does not have a question about your driving safety as outlined in WAC 388-891-0775.

(2) The DVR counselor has determined based on disability-related documentation that your disability is stable or slowly progressive and not likely to impair your driving ability in the future, if you plan to drive the vehicle.

(3) You have provided documentation verifying that you and/or a family member is the registered and/or legal owner of the vehicle.

(4) You have provided a copy of a current driver's license and vehicle license with required endorsements for you and/or family member(s) who will operate the vehicle.

(5) If a used vehicle is to be modified, you have provided documentation of an inspection from a certified or journey level auto mechanic that verifies the vehicle is in good condition and capable of being modified.

(6) DVR has obtained documentation from a specialist in evaluation and modification of vehicles for individuals with disabilities that prescribes and inspects the modification, except prescriptions are not required for:

(a) Placement of a wheelchair lift, ramp, or scooter lift and tie downs for passenger access only;

(b) Replacement of hand controls;

(c) Wheelchair carriers; and

(d) Other minor driving aids.

(7) You have provided documentation of vehicle insurance adequate to cover the cost of replacement for loss or damage, including the cost of the modification.

(8) You have demonstrated or provided documentation that verifies you and/or family member(s) designated as a driver can safely operate the vehicle as modified.

[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, § 388-891-0665, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0670 What types of insurance can DVR pay for? (1) DVR may pay for insurance for assistive technology devices, equipment and products.

(2) DVR does not pay for other types of insurance including, but not limited to, health, vehicle, home, and life insurance.

[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, § 388-891-0670, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0675 What types of assistive technology insurance can DVR pay for? DVR may pay for insurance for assistive technology devices, equipment, and products which covers the cost to repair or replace them if they are lost or damaged if:

(1) The individual with a disability is the holder of the device, equipment or product and is the named insured under the policy; and

(2) The insurer pays for replacement or repair directly to the manufacturer or service provider.

[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, § 388-891-0675, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0680 What types of assistive technology warranties can DVR pay for? (1) DVR may pay for an initial warranty for an assistive technology device, piece of equipment, or product for a specified period of time following the date of purchase if the warranty is available at the time of purchase by the manufacturer. An initial warranty may guarantee repair and/or replacement of parts or the entire device, equipment, or product when the parts and/or workmanship are faulty.

(2) DVR may pay for an initial warranty or for a warranty that extends beyond the period of coverage of an initial warranty for an assistive technology device, piece of equipment, or product if:

(a) The individual with a disability is the holder of the device, equipment, or product;

(b) The manufacturer provides a written guarantee for the materials and workmanship of the device, equipment, or product; and

(c) The manufacturer replaces or repairs faulty parts and workmanship or replaces the device, equipment, or product in whole or the manufacturer directly pays a service provider to repair or replace parts and workmanship or the device, equipment, or product in whole.

[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, § 388-891-0680, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0685 What are self-employment services? Self-employment services include consultation and technical assistance to help you establish a small business to become self-employed and equipment, tools, initial stocks and supplies. Before a DVR counselor agrees to an IPE that includes a self-employment outcome, you must complete assessment services, including the development of a business plan that demonstrates that the self-employment you are considering is feasible, sustainable, and results in an employment outcome. DVR does not support hobbies or activities that do not result in an income-producing self-employment outcome.

[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, § 388-891-0685, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0690 What vocational rehabilitation services can DVR provide to my family member(s)? Vocational rehabilitation services may be provided to a family member if the services are necessary for you to achieve an employment outcome. A family member includes a relative or guardian of an applicant or eligible individual or an individual who lives in the same household as the applicant or eligible individual and has a substantial interest in her or his well being.

[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, § 388-891-0690, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0695 What types of child care does DVR provide to my family members? (1) DVR pays for the following types of licensed child care and child care exempt from licensing in conformance with DSHS licensing or certification requirements and background check requirements:

(a) Child day care centers;

(b) Family child day care homes; and

(c) School-age child care centers.

(2) DVR pays for in-home or relative child care including:

(a) Child care provided to your child(ren) in your home by a relative or other person; and

(b) Child care provided to your child(ren) by a relative outside of your home.

(3) To be authorized as an in-home/relative child care provider for DVR payment, your in-home or relative child care provider must comply with background check requirements outlined in chapter 388-290 WAC.

(4) DVR pays for child care in states bordering Washington if the child care provider meet their state's licensing regulations.

(5) DVR pays the child care provider's usual rates for child care services directly to the child care provider.

[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, § 388-891-0695, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0700 What is substantial counseling and guidance? Substantial counseling and guidance includes intensive counseling and guidance provided by a DVR counselor throughout the rehabilitation process to help you address medical, family or social issues, vocational counseling, or other counseling and guidance that is over and above the usual counseling and guidance relationship. Substantial counseling and guidance services include counseling and guidance to support a self-directed job search.

[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, § 388-891-0700, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0705 What are tools, equipment, initial stocks and supplies? Tools, equipment, initial stocks and supplies are materials and hardware required to carry out the duties of a job.

[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, § 388-891-0705, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0710 What are training services? Training services are designed to help you gain knowledge, skills and abilities needed to achieve an employment outcome. Training services, include, but are not limited to:

(1) On-the-job training;

(2) Post-secondary training;

(3) Technical or vocational training;

(4) Basic education/literacy training;

(5) Community rehabilitation program (CRP) training;

(6) Other miscellaneous training.

[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, § 388-891-0710, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0715 What is on-the-job training? On-the-job training is training an employer provides to you after you are placed in a job to help you learn the skills you need. The employer must sign an agreement to include at a minimum:

(1) Training to be provided, including skills to be learned and training methods;

(2) Duration or number of hours of training to be provided;

(3) How the employer will evaluate and report your progress to DVR;

(4) An agreed-upon fee based on the employer's costs to provide the training; and

(5) Payment criteria.

[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, § 388-891-0715, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0720 What is post-secondary training? Post-secondary training means academic training above the high school level leading to a degree, an academic certificate, or other recognized educational credential. Post-secondary training is provided by a college or university, community college, junior college or technical college.

[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, § 388-891-0720, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0725 What is technical or vocational training? Technical or vocational training includes occupational, vocational or specific job skill training, not leading to an academic degree, provided by a community college, business school, vocational, technical or trade school to prepare for work in a specific occupation.

[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, § 388-891-0725, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0730 What is basic education/literacy training? Basic education/literacy training teaches basic academic skills, including how to read.

[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, § 388-891-0730, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0735 What is community rehabilitation program (CRP) training? Community rehabilitation program (CRP) training is training to prepare an individual for work, such as developing appropriate work habits and behaviors, getting to work on time, dressing appropriately, and/or skills to increase productivity.

[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, § 388-891-0735, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0740 What other training does DVR provide? DVR provides other miscellaneous training services that are not identified in another section, such as high school completion, speech reading or sign language training, cognitive training and tutoring.

[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, § 388-891-0740, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0745 What conditions apply to receiving training services at an institution of higher education? (1) Training at an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) is provided only after you and a DVR counselor have made maximum efforts to get and use available grant funding from other sources to pay for costs related to attendance. Grant funding does not include student loans.

(2) You must provide DVR a copy of your grant funding award or denial form, statement of unmet need and/or student budget, and other related documentation.

(3) If an academic institution charges a fee to cover the cost of a student health clinic and the fee is required as a condition of registration, DVR may pay this fee.

(4) If an academic institution charges a liability fee to cover the costs of a student to register in high-risk courses/practicum and the fee is required as a condition of registration, DVR may pay this fee.

[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, § 388-891-0745, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0750 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? If you choose training services at a private or out-of-state program when an in-state or public program is available and adequate to meet your needs, you are responsible for costs that are in excess of the public or in-state program costs.

[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, § 388-891-0750, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0755 What are transition services? (1) Transition services are work-related activities you begin while you are in high school that are coordinated with VR services to help you prepare for and go to work in the community after you leave high school.

(2) Transition services may include any of the VR services listed under WAC 388-891-0600.

[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, § 388-891-0755, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0760 What are translation services? Translation services include oral and written translation of English into the primary language of an applicant or eligible individual.

[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, § 388-891-0760, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0765 What are transportation services? Transportation services include travel and related expenses necessary for you to participate in VR services, such as a bus pass, reimbursement for gasoline, purchase or repair of a vehicle.

[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, § 388-891-0765, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0770 Under what conditions does DVR provide a vehicle? (1) DVR provides a vehicle as a transportation service only in exceptional circumstances to support another VR service on the IPE and must be approved by the director or his or her designee.

(2) A vehicle issued to you remains the property of DVR until you achieve an employment outcome that requires the vehicle and you maintain the employment for at least ninety days.

(3) The director or his or her designee approves the purchase of a vehicle only if:

(a) A DVR counselor determines, based on disability-related documentation that your disability is stable or slowly progressive, and is not likely to impair your ability to drive in the future;

(b) You and a DVR counselor agree it is a necessary service under your individualized plan for employment (IPE) because:

(i) No other transportation options are available and it is not feasible for you to relocate to live closer to employment or other transportation options; or

(ii) A vehicle is required as a condition of employment.

(c) You do not have a vehicle or your vehicle cannot be modified or repaired to the extent that you can drive it.

(4) Prior to issuing a vehicle to you, you must submit the following documents to DVR and you must agree to provide ongoing verification upon request of a DVR counselor:

(a) A copy of your current, valid driver's license;

(b) A copy of your driving record disclosing any moving violations and indicating no criminal convictions related to driving a vehicle;

(c) A copy of your motor vehicle insurance coverage with the following minimum coverage and conditions:

(i) Liability in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(ii) Uninsured motorist in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(iii) Personal injury in the amount of one hundred thousand dollars;

(iv) Replacement cost of the vehicle, including special equipment and modifications, if applicable;

(v) DVR is listed as the lien holder; and

(vi) All drivers who use the vehicle are listed on the policy.

(d) You have signed a written agreement with your DVR counselor that outlines how you will pay for vehicle maintenance and repair, as this is a requirement for subsequent ownership of the vehicle;

(e) You have signed an agreement to return the vehicle to DVR upon request as long as DVR owns the vehicle.

(5) Before DVR transfers ownership of a vehicle to you, you must submit documentation to verify:

(a) You are the registered owner of the vehicle;

(b) The vehicle is insured to cover the cost of replacement for loss or damage at the time ownership is transferred.

[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, § 388-891-0770, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0775 What happens if DVR has a question about my driving safety? (1) DVR does not provide services to facilitate your driving or that of a driver using your vehicle if:

(a) Either you or the driver are uninsured; or

(b) DVR is aware of any fact which raises a question regarding driving safety.

(2) Services to facilitate your driving include, but are not limited to, vehicle modifications provided as a rehabilitation technology service, car repairs, gasoline money, driver license, and license tabs.

[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, § 388-891-0775, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0780 What other services does DVR provide? DVR can provide other services not identified in this chapter when the service is needed for you to achieve an employment outcome.

[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, § 388-891-0780, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0790 What are post-employment services? Post-employment services include one or more vocational rehabilitation services provided if:

(1) Your case was closed within the past three years because you achieved an employment outcome;

(2) Your rehabilitation needs are limited in scope and duration;

(3) You need post-employment services to maintain, regain or advance in employment that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

[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, § 388-891-0790, filed 12/20/02, effective 2/3/03.]

SUPPORTED EMPLOYMENT

WAC 388-891-0800 What is supported employment? (1) Supported employment is:

(a) Competitive work; or

(b) Work in an integrated setting while you work toward competitive work consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; or

(c) Transitional employment for an individual with a most severe disability due to chronic mental illness.

(2) Supported employment is for an individual with a most severe disability who:

(a) Has not traditionally worked in competitive employment; or

(b) Has worked in competitive employment, but the disability has caused the individual to stop working, or work off and on; and

(c) Needs intensive supported employment services and extended services to work because of the nature and severity of the disability.

[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, § 388-891-0800, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0810 Who is eligible for supported employment? You are eligible for supported employment services if:

(1) You are eligible for vocational rehabilitation services under WAC 388-891-1000;

(2) You have been determined to be an individual with a most severe disability; and

(3) Supported employment is appropriate for you based on a comprehensive assessment of your needs, including an evaluation of your rehabilitation, career and job needs.

[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, § 388-891-0810, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0815 Who decides if I am eligible for supported employment? DVR decides if you are eligible for supported employment services.

[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, § 388-891-0815, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0820 What is competitive work in supported employment? Competitive work, as used in supported employment, is:

(1) Work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting; and

(2) Work for which you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled employees who do the same or similar work as you.

[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, § 388-891-0820, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0825 What is an integrated setting in supported employment? An integrated setting in supported employment is a work setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with other persons.

[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, § 388-891-0825, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0830 Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers? Interactions at your work site between you and a nondisabled supported employment service provider do not meet the requirement for an integrated setting.

[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, § 388-891-0830, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0835 What is transitional employment? Transitional employment is a supported employment work model using a series of consecutive jobs in competitive employment for individuals with the most severe disabilities due to mental illness. In transitional employment, ongoing support services must include continuing sequential job placement until job permanency is achieved.

[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, § 388-891-0835, 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 388-891-0845 What are ongoing support services? Ongoing support is a type of supported employment service to help you get and keep a job. Ongoing support services include:

(1) An assessment of your employment situation at least twice a month, or under special circumstances and especially at your request, an assessment regarding your employment situation that takes place away from your worksite at least twice a month to:

(a) Determine what is needed to maintain job stability; and

(b) Coordinate services or provide specific intensive services that are needed at or away from your worksite to help you maintain job stability.

(2) Intensive job skill training for you at your job site by skilled job trainers;

(3) Job development, job placement and job retention services;

(4) Social skills training;

(5) Regular observation or supervision;

(6) Follow-up services such as regular contact with your employer, you, your representatives, and other appropriate individuals to help strengthen and stabilize the job placement;

(7) Facilitation of natural supports at the worksite;

(8) Other services similar to services described in subsection (1) through (7) above; and

(9) Any other vocational rehabilitation service.

[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, § 388-891-0845, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0850 What are extended services? Extended services help you keep your job after DVR stops providing or paying for supported employment services.

[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, § 388-891-0850, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0855 Does DVR provide extended services? DVR does not provide extended services.

[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, § 388-891-0855, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0860 Who provides the extended services I need? Extended services are provided by nonprofit private organizations such as community rehabilitation programs, state and local public agencies, employers, or any other appropriate resources.

[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, § 388-891-0860, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0865 What is natural support? Natural support is a method used to help you keep your job after DVR stops providing supported employment services. Natural support uses the people who you ordinarily come into contact with at work and/or at home to help you with work routines and social interactions at the worksite.

[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, § 388-891-0865, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0875 What is required for me to change from supported employment services to extended services? Prior to helping you change from supported employment services to extended services, a DVR counselor must ensure the following:

(1) You have made substantial progress toward meeting the number of work hours per week you want to work as documented on your individualized plan for employment;

(2) You are stabilized in the job; and

(3) Extended services are readily available and can be provided to you without an interruption in services.

[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, § 388-891-0875, 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 388-891-0885 Under what conditions does DVR close my case service record for supported employment? If you have achieved a supported employment outcome, DVR must wait at least ninety days after helping you change from supported employment services to extended services before closing your case service record.

[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, § 388-891-0885, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0890 Under what conditions does DVR provide supported employment services as post-employment services? DVR provides supported employment services to you as post-employment services following the change from supported employment services to extended services if:

(1) Your extended service provider cannot provide the services; and

(2) You need such services as job station redesign, repair and maintenance of assistive technology devices and replacement of prosthetic and orthotic devices to keep your job.

[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, § 388-891-0890, filed 12/20/02, effective 2/3/03.]

APPLYING FOR VR SERVICES

WAC 388-891-0900 Who can apply for vocational rehabilitation services? Any individual who intends to achieve an employment outcome may apply for VR services.

[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, § 388-891-0900, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0910 Am I required to provide proof of my identity and work status? Before DVR pays for VR services, including assessment services, you must provide copies of documents requested by DVR that verify your identity and, if you are not a United States citizen, your legal work status.

[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, § 388-891-0910, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0920 If I don't live in Washington, can I receive VR services? The state in which you live has the primary responsibility to provide VR services to you. If you are not a resident of Washington state, you may receive VR services if you maintain a home, are registered to vote, or are otherwise present in the state.

[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, § 388-891-0920, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0930 Can I receive VR services if I am legally blind? The Washington state department of services for the blind, under an agreement with DVR, is the primary agency responsible for providing vocational rehabilitation services to individuals who are blind or have a visual impairment resulting in an impediment to employment. DSB and DVR may coordinate to provide joint services if you would benefit from such coordination.

[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, § 388-891-0930, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0940 Can I receive VR services if I am Native American? DVR serves eligible Native Americans, including Native Americans who belong to an Indian tribe. If you live on an Indian reservation that operates a vocational rehabilitation program, you may apply for VR services from the tribe or from DVR, or from both agencies.

[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, § 388-891-0940, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0950 How do I contact DVR if I don't speak English? If you don't speak English, you may request another type of communication to enable you to meet with DVR. DVR arranges and pays for services you need to communicate with DVR to apply for or receive VR services.

[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, § 388-891-0950, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0960 What other methods of communication does DVR use? DVR uses equipment, devices or other services you need to understand and respond to information. Methods DVR can use to communicate with you include, but are not limited to, the use of:

(1) Interpreters;
(2) Readers;
(3) Captioned videos;
(4) Telecommunications devices and services;
(5) Taped text;
(6) Braille and large print materials; and
(7) Electronic formats.

[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, § 388-891-0960, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0970 Does DVR translate written communication for people who don't speak English? (1) DVR translates the following written communication into the primary language of an applicant or eligible individual:

(a) Application for VR services;
(b) Notification of eligibility or ineligibility;
(c) Plan for employment;
(d) Notification of case closure;
(e) Notification of annual review, if appropriate; and
(f) Any notice requiring a response or a signature from the individual to continue receiving services.

(2) DVR translates the Washington Administrative Code (WAC) regarding VR services or service providers into the primary language of an applicant or eligible individual upon his or her request.

[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, § 388-891-0970, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0980 How do I apply for VR services? You have completed the application requirements when you:

(1) Have provided information needed to begin an assessment of eligibility and VR needs.

(2) Are available to participate in assessment services necessary to determine if you are eligible for VR services.

(3) Have signed an application form provided by DVR or provided a written request that includes the following information:

(a) Your name, address and county;
(b) The nature of your disability;
(c) Your birth date and gender;
(d) The date of application; and
(e) Your Social Security Number (optional).

[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, § 388-891-0980, filed 12/20/02, effective 2/3/03.]

ELIGIBILITY

WAC 388-891-1000 Who is eligible to receive VR services? You are eligible for VR services if a DVR counselor determines that you meet all of the following criteria:

(1) You have a physical, mental, or sensory impairment that results in a substantial impediment to employment;

(2) You require VR services to prepare for, get or keep a job that matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and

(3) You are capable of working as a result of receiving VR services.

[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, § 388-891-1000, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1005 How does DVR determine if I am eligible? (1) A DVR counselor reviews and assesses information and records about the current status of your disability and determines whether you meet the eligibility requirements outlined in WAC 388-891-1000. A DVR counselor bases the determination on observations, education records, medical records, information provided by you or your family, and information provided by other agencies or professionals.

(a) If information or records are not current, not available, or not sufficient for a DVR Counselor to determine if you are eligible, DVR provides the assessment services necessary to get the information needed to make a decision.

(b) VR services used to collect additional information and records to determine eligibility can include trial work, assistive technology, personal assistant services, or any other support services necessary to determine if you are eligible.

(c) DVR assists you to make informed choices in the decisions related to assessment services needed to make an eligibility determination.

(d) If you refuse to provide or consent to the release of records or if you refuse to participate in VR services necessary to obtain information required to make an eligibility determination your VR case service record is closed.

(2) If you receive Social Security benefits under Title II or Title XVI of the Social Security Act and you are capable of working after receiving VR services, DVR determines you are eligible upon verification of benefits.

(a) If you cannot provide appropriate evidence, such as an award letter or other type of verification, DVR may request the verification for you, with your consent.

(b) DVR makes maximum efforts to obtain the verification in a reasonable period of time and to determine eligibility within sixty days from the date you complete the application requirements.

[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, § 388-891-1005, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1010 After I submit my application to DVR, how long does it take DVR to make an eligibility decision? (1) DVR makes an eligibility decision as soon as enough information is available, but no longer than sixty days after you complete the application requirements.

(2) If DVR does not have enough information to determine your eligibility within sixty days, you and a DVR counselor must agree to:

(a) Extend the eligibility period to collect additional information or records; or

(b) Conduct a trial work experience or extended evaluation, if a DVR counselor is not certain whether VR services will enable you to achieve an employment outcome because of the severity of your disability

(3) If you do not agree to extend the eligibility period, DVR must close your case service record.

[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, § 388-891-1010, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1015 What if a DVR counselor cannot presume that I am capable of working as a result of receiving VR services because of the severity of my disability? If a DVR counselor cannot presume VR services will enable you to achieve an employment outcome because of the severity of your disability, DVR will assess your ability to perform work using a trial work experience or an extended evaluation. The DVR counselor will evaluate the results of the trial work experience or extended evaluation to determine whether you can work as a result of receiving VR services and whether you are eligible for VR services.

[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, § 388-891-1015, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1020 Am I eligible for VR services if I receive Social Security disability benefits? If you receive disability benefits under Title II or XVI of the Social Security Act (SSI or SSDI), DVR presumes that you are an eligible individual.

[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, § 388-891-1020, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1025 What criteria are not considered in the eligibility decision? In making an eligibility decision, DVR does not consider your:

(1) Type of disability;

(2) Age, gender, race, color, creed, religion, national origin, or sexual orientation;

(3) Rehabilitation needs;

(4) Type of employment outcome you expect to achieve;

(5) Source of referral;

(6) Anticipated cost of services;

(7) Income.

[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, § 388-891-1025, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1030 What is involved in a trial work experience? (1) During a trial work experience, you perform in a realistic work situation with appropriate VR services and/or supports to address your rehabilitation needs, such as supported employment, on-the-job training, assistive technology or personal assistant services. A DVR counselor develops a written plan describing the VR services to be used in the trial work experience.

(2) You participate in one or more trial work experiences over a period of time necessary to produce clear and convincing evidence for a DVR counselor to determine:

(a) You can benefit from VR services and achieve an employment outcome and are eligible for VR services; or

(b) You cannot benefit from VR services and achieve an employment outcome because of the severity of your disability and you are ineligible for VR services.

(3) Trial work experiences occur in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[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, § 388-891-1030, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1035 What if I cannot participate in a trial work experience? If you cannot participate in a trial work experience or if DVR has exhausted efforts to arrange a trial work experience, DVR conducts an extended evaluation to obtain the information necessary to determine whether you are eligible for VR services or to enable you to participate in a trial work experience.

[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, § 388-891-1035, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1040 What is an extended evaluation? An extended evaluation involves one or more VR services designed to assess whether you are capable of working as a result of receiving VR services. A DVR counselor develops a written plan outlining the VR services to be used during the extended evaluation. Only those services necessary to make an eligibility determination are provided. VR services are provided in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[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, § 388-891-1040, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1045 What happens if DVR determines that I am not eligible or no longer eligible for VR services? (1) Before determining that you are not eligible for VR services or that you are no longer eligible for VR services, a DVR counselor consults with you and gives you an opportunity to discuss the decision.

(2) DVR sends you a notice in writing, or using another method of communication, if needed. The notice includes:

(a) An explanation of the reason(s) you are not eligible or no longer eligible;

(b) Your rights to appeal the decision; and

(c) An explanation of the services available from the client assistance program.

(3) If you are ineligible based on a determination that you cannot achieve employment because of the severity of your disability, DVR reviews the decision within twelve months.

[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, § 388-891-1045, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1050 If I am not eligible for VR services, can DVR help me find other services and programs to meet my needs? If DVR determines that you are not eligible for VR services, DVR provides you with information and refers you to other agencies or organizations that may provide services to meet your employment-related needs. This may include a referral to community rehabilitation programs offering extended employment (sheltered work) if you are determined ineligible based on a determination that you are too severely disabled to achieve employment as a result of receiving VR services.

[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, § 388-891-1050, filed 12/20/02, effective 2/3/03.]

IPE DEVELOPMENT

WAC 388-891-1100 What is an assessment for determining vocational rehabilitation needs? Each person determined eligible for VR services completes an assessment of VR needs that may include:

(1) An assessment for determining vocational rehabilitation needs includes a variety of services, including counseling and guidance, to determine your unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) The purpose of the comprehensive assessment is to collect and review information you need to select the type of employment outcome to achieve and the VR services you need to achieve the employment outcome.

(3) The comprehensive assessment is limited to services necessary to select an employment outcome and to develop a plan for employment.

(4) DVR uses existing information gathered to determine eligibility, including information provided by you and your family, to the maximum extent possible and appropriate.

(5) The comprehensive assessment may include, as needed:

(a) An assessment of the personality, interests, interpersonal skills, intelligence and related functional abilities, educational abilities, work experience, vocational aptitudes, personal and social adjustments, employment opportunities, and other vocational, educational, cultural, social, recreational, and environmental factors that affect your employment and rehabilitation needs.

(b) Work in real job situations to evaluate and/or develop work behavior and capacities necessary to achieve an employment outcome, including work skills, attitudes, habits, tolerances and social behavior.

(c) Referral for assistive technology services to assess whether services or devices could increase your ability to perform work.

[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, chap-

ters 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, § 388-891-1100, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1105 Do I have to disclose criminal history information to DVR? (1) You must disclose information to DVR before you develop a plan for employment about conditions or circumstances, such as a criminal record, identity and work status, that restrict the type of employment you can legally perform.

(2) If you select an employment outcome in a field that customarily requires a background check as a condition of employment, DVR must obtain a criminal history background check that verifies you are not excluded from employment in the field and/or specific job prior to IPE development.

[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, § 388-891-1105, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1110 What other assessments might be required? (1) If you have a documented history of violent or predatory behavior that reasonably leads a DVR counselor to believe you may be a threat to yourself or others, you must participate in VR services necessary to determine the level of risk.

(2) If a VR counselor determines, based on an assessment conducted by a qualified professional, that your employment may pose a threat to the safety of you or others because you meet the conditions outlined in WAC 388-891-0110, the employment outcome and employment setting you choose must be evaluated for risk by an appropriate qualified professional.

(3) If a VR counselor becomes aware of a condition or circumstance after you have developed an IPE that may affect your ability to achieve an employment outcome, the VR counselor may conduct necessary assessment services to determine whether you are capable of achieving the employment outcome identified on your IPE.

(4) If you decline to authorize the release of information to DVR or participate in VR services necessary to collect pertinent information which prevents the development of an appropriate IPE, the VR counselor may close your case service record.

[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, § 388-891-1110, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1115 What is an individualized plan for employment (IPE)? An individualized plan for employment (IPE) is a DVR form that documents important decisions you and a VR counselor make about vocational rehabilitation services. The decisions documented on the IPE include, but are not limited to:

(1) The employment outcome you plan to achieve;

(2) Each major step you need to accomplish to reach the employment outcome;

(3) Your responsibilities in accomplishing each step of the plan;

(4) DVR's responsibilities in assisting you to accomplish each step of the plan;

(5) VR services needed to complete each step;

(6) Terms and conditions you and your VR counselor agree are required for continued support from DVR.

[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, § 388-891-1115, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1120 Who develops an IPE? Each eligible individual develops an IPE, unless DVR is operating under an order of selection. If DVR is operating under an order of selection, each eligible individual in the priority category being served develops an IPE.

[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, § 388-891-1120, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1125 What information does DVR provide to help me develop my IPE? DVR provides the following information to help you develop an IPE:

(1) Information about the options available for developing an IPE.

(2) Information that must be included in the IPE.

(3) Financial conditions or restrictions that apply to an IPE.

(4) How to get help completing forms required by DVR.

(5) Information about your rights if you disagree with a decision a DVR counselor makes relating to the IPE.

(6) Information about the client assistance program (CAP) and how to contact the program.

(7) Other information you request.

[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, § 388-891-1125, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1130 What are the options for developing an IPE? (1) You may develop an individualized plan for employment (IPE) with support and assistance from:

(a) A VR counselor employed by DVR.

(b) A VR counselor not employed by DVR, but who meets the minimum qualifications for a VR counselor established by DVR.

(c) Another person you choose, such as a representative, family member, advocate, or other individual.

(2) If you choose to develop the IPE with someone other than a DVR counselor, DVR can help you identify individuals that may help you develop your IPE, to the extent resources are available.

(3) You may develop an IPE on your own.

(4) DVR does not pay for any related costs or fees charged by other parties to develop an IPE.

[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, § 388-891-1130, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1135 Does DVR support any job I choose? (1) The employment outcome you choose must be consistent with the information and results of the assessment of your VR needs.

(2) DVR supports an individual to achieve an employment outcome as defined in WAC 388-891-0010. If you choose another type of employment, DVR refers you to other programs or organizations that offer the type of employment you choose, when available.

[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, § 388-891-1135, 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 388-891-1140 What must be included on the IPE form? An IPE must include:

(1) An employment outcome that is consistent with the definition of employment outcome in WAC 388-891-0010;

(2) The VR services you need to achieve the employment outcome;

(3) Timeline for each service on your IPE and for achieving the employment outcome;

(4) The name of the person or organization selected to provide each service included on the IPE and how you will obtain the services;

(5) Criteria you will use to evaluate whether you are making progress toward achieving the employment outcome;

(6) Terms and conditions, including:

(a) A description of what DVR has agreed to do to support your IPE; and

(b) A description of what you have agreed to do to reach your employment outcome, including:

(i) Steps you will take to achieve your employment goal;

(ii) Services you agree to help pay for, and how much you agree to pay; and

(iii) Services you agree to apply for and use that are available to you at no cost from another program.

(7) Expected need for post-employment services prior to closing the case service record and, if appropriate, a statement of how post employment services are arranged using comparable services and benefits;

(8) An IPE that includes a supported employment outcome must also document:

(a) Supported employment services to be provided;

(b) Extended services or natural supports that are likely to be needed;

(c) Who will provide and pay for natural supports or extended services. If it is not known who will provide and/or pay for extended services or natural supports at the time the IPE is developed, the IPE must include a statement explaining the basis for determining that a resource is likely to become available;

(d) A goal for the number of hours per week you are going to work and a plan to monitor your progress toward meeting the goal;

(e) A description of how the services on your IPE are coordinated with other federal or state services you get under an individualized plan;

(f) If job skills training is provided, the IPE must reflect that the training is provided on-site;

(g) Placement in an integrated setting for the maximum number of hours possible based on your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(9) An IPE for a high school student who is receiving special education services is coordinated with the individualized education plan in terms of the goals, objectives, and services identified to the extent possible.

[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, § 388-891-1140, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1145 When does the IPE become effective? The IPE becomes effective when it is signed by you and a DVR counselor. DVR gives you a copy of the signed IPE, in writing or in another method of communication, if needed.

[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, § 388-891-1145, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1150 Is the IPE reviewed and updated? You and a qualified VR counselor review the IPE at least once a year, or more often if needed, to assess your progress in achieving an employment outcome. You and a VR counselor amend the IPE if there are major changes in the employment goal, VR services, or service provider(s). Changes to an IPE take effect when you and a DVR counselor sign the amended IPE.

[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, § 388-891-1150, filed 12/20/02, effective 2/3/03.]

LOANING EQUIPMENT

WAC 388-891-1200 Under what conditions does DVR loan equipment, devices or other items to me? If you need a device, tool, piece of equipment or other item to participate in VR services or to go to work, DVR loans a new or used item to you until you achieve an employment outcome. DVR loans a used item from the DVR inventory if available at the time needed and DVR determines it is adequate to meet your needs.

[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, § 388-891-1200, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1210 What if I need an item customized for my own personal needs? A DVR counselor determines whether to loan or issue a device, tool, piece of equipment or other item based on the reasonable likelihood that the item could be used by another individual if returned to DVR. If the DVR counselor determines an item could not be used by another individual if it were returned to DVR, the DVR counselor may issue the item directly to you without a loan agreement and the item is owned by you at the time of issue.

[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, § 388-891-1210, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1220 What conditions apply to the use of a device, tool, piece of equipment or other item that is loaned to me? Before DVR loans an item to you, you must sign an agreement with DVR to comply with the following conditions:

(1) You agree to immediately return the item upon request or to pay for the item if you cannot return it to DVR;

(2) You agree to maintain the item according to DVR instructions and manufacturer's guidelines, if applicable, and keep it secure from damage, loss or theft.

[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, § 388-891-1220, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1230 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR? If DVR directs you to return an item loaned to you and you do not immediately return it, DVR reports the loss to the DSHS office of financial recovery (OFR). The OFR attempts to recover the item or payment for the item from you. If the OFR cannot recover the item or payment for the item from you, the OFR may report the loss to the local county prosecutor for legal action.

[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, § 388-891-1230, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1240 What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed? DVR may transfer ownership of the device, tool, piece of equipment or other item to you at the time a DVR counselor closes your case service record if you have achieved an employment outcome and you need the item to keep your job.

[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, § 388-891-1240, filed 12/20/02, effective 2/3/03.]

CASE CLOSURE

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.]

WAC 388-891-1310 How does DVR determine that I have achieved an employment outcome? DVR determines that you have achieved an employment outcome and no longer need VR services if:

(1) You received services under an IPE that helped you achieve the employment outcome on your employment plan;

(2) Your job matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice;

(3) You have been working at the same job for at least ninety days to ensure the stability of your employment; and

(4) You and a DVR counselor agree the job is satisfactory, that you are performing the job well, and that you no longer need VR services.

[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, § 388-891-1310, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1320 Am I involved in the decision to close my case? Before closing your case, a DVR counselor gives you an opportunity to discuss the decision. DVR notifies you in writing, or another method of communication, if needed, about the reason your case is being closed and your rights if you disagree with the decision.

[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, § 388-891-1320, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1330 Under what conditions does DVR follow up with me after my case is closed? (1) DVR contacts you within twelve months after your case service record is closed and annually for two years after that to

review whether anything has changed to affect your eligibility if:

(a) DVR closes your case after determining you are ineligible because you are too severely disabled to achieve an employment outcome as a result of VR services;

(b) You achieve a supported employment outcome and earn wages under section 14(c) of the Fair Labor Standards Act while working toward competitive employment;

(c) You choose extended employment; or

(d) You and your DVR counselor cannot find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for supported employment.

(2) After DVR completes the reviews annually for two years, you or your representative may request additional annual reviews.

[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, § 388-891-1330, filed 12/20/02, effective 2/3/03.]

Chapter 388-892 WAC

PURCHASE OF SERVICES—SELECTION CRITERIA—DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

WAC

VOCATIONAL REHABILITATION SERVICES DVR PURCHASES BY CONTRACT

WAC 388-892-0100 What vocational rehabilitation (VR) services does DVR purchase by contract? DVR purchases the following VR services by contract:

(1) Vocational evaluation services,

(2) Job placement/retention services,

(3) Transitional employment services.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0100, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0110 What are vocational evaluation services? There are three types of vocational evaluation services:

(1) "Brief" vocational assessment services are:

(a) Paper and pencil tests, such as psychometric testing, personality testing, preference and interest inventories that identify an individual's work interests and abilities; and

(b) Typically completed in one day or less.

(2) Comprehensive vocational evaluation services:

(a) Consist of tests and/or assessment methods designed to measure and document an individual's interests, values, work related-behaviors, aptitudes, skills, physical capacities, learning styles and training needs;

(b) Are performed using a variety of techniques, i.e., assessment of functional/occupational performance in real or simulated environments, work samples, psychometric testing, preference and interest inventories, personality testing, personal interviews and analysis of prior work experience and transferable skills;

(c) Identify at least three employment options that the individual could successfully perform either with or without training and long-term employment supports; and

(d) May be completed in three days or less but may vary, more or less, to accommodate the unique needs and abilities of individuals receiving this service.

(3) Situational assessment services are:

(a) Experiences in which individuals perform work in an actual paid employment setting or other realistic work setting to identify an individual's unique work interests and abilities;

(b) Conducted over a negotiated period of time depending on the individual's needs.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0110, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0120 What are job placement/retention services? (1) Job placement/retention services mean referral of an individual to a specific job that results in a competitive employment job placement, training activities that enable an individual to adequately perform essential job functions and provision of services after job placement and training to enable an individual to retain their job for a minimum of ninety calendar days.

(2) There are two types of job placement/retention services—"general" and "specialized."

(a) General job placement/retention services are provided for individuals who need job placement assistance without additional on-the-job supports.

Individuals requiring general job placement/retention services may include, but are not limited to, those who meet one or more of the following conditions:

(i) Graduated from high school or attained a GED;

(ii) Successfully completed some post high school training, such as vocational/technical school or college academic program;

(iii) Have a recent and/or stable work history;

(iv) Were employed at the time of application for DVR services; or

(v) Have a high level of gross motor skills and/or cognitive functioning.

(b) Specialized job placement/retention services are provided for individuals who, as determined by DVR, require a high level of support prior to or during the initial phases of job placement and/or additional supports after job placement to achieve satisfactory job performance and retain the job.

Individuals requiring specialized job placement/retention services may include, but not limited to, those who meet one or more of the following conditions:

(i) Have received SSI/SSDI or other types of public assistance;

(ii) Have received special education services;

(iii) Did not graduate from high school or attain a GED;

(iv) Have little or no work history;

(v) Have not worked in the previous two years;

(vi) Experience significant cognitive or sensory impairments; or

(vii) Have a criminal history and/or are subject to a community protection order.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0120, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0130 What levels of support are available under specialized job placement/retention services? Specialized job placement/retention services include two levels - level 1 and level 2:

(1) Level 1 services are provided for individuals who, as determined by DVR, may require a high level of support prior to or during the initial phases of job placement but do not require ongoing supported employment services to maintain their job after DVR closes the case.

(2) Level 2 services are provided for individuals who, as determined by DVR, require ongoing supported employment services to maintain their job after DVR closes the case.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0130, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0140 What are transitional employment (TE) services? Transitional employment services:

(1) Meet the vocational rehabilitation needs of individuals with severe and persistent mental illness.

(2) Assess and build an individual's skills and abilities in a real work setting.

(3) Utilize the clubhouse programs model/international center for club house development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0140, filed 9/12/03, effective 10/13/03.]

DVR VOCATIONAL REHABILITATION SERVICE CONTRACT PROCUREMENT

WAC 388-892-0200 How does DVR procure vocational evaluation, job placement/retention and transitional employment services? (1) DVR contracts with qualified service providers for the provision of vocational evaluation, job placement/retention and transitional employment services through a request for qualifications (RFQ) contract procurement process that is administered by DVR.

(2) A qualified provider is one that meets all DVR qualifications for a VR service contract as outlined in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0200, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0210 How does an RFQ work? (1) RFQs are issued on a periodic cycle to be determined by DVR, for example, every two years. The duration of the VR service contracts resulting from the RFQ will be announced in the RFQ. DVR reserves the right to extend the contracts by offering up to three one-year extensions.

(2) DVR may advertise the RFQ in a variety of ways, including but not limited to the DVR web site, newspapers, and notices sent to potentially interested contractors.

(3) The scope of work, fee to be paid, and contractor qualifications are defined in a separate RFQ and contract for each specific type of VR service:

(a) Brief vocational assessment,

(b) Comprehensive vocational evaluation,

(c) Situational assessment,

(d) General job placement/retention,

(e) Specialized job placement/retention level 1,

(f) Specialized job placement/retention level 2, and

(g) Transitional employment.

(4) Service providers, that are interested in obtaining a VR service contract as outlined in the RFQ, are instructed to submit their qualifications.

(5) First time respondents that demonstrate full conformance to the uniform VR service contract qualifications, as outlined in this chapter, may be granted an initial VR service contract.

(6) DVR may limit the number of VR service contracts it issues in a service delivery area as a result of an RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0210, filed 9/12/03, effective 10/13/03.]

INITIAL DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

WAC 388-892-0300 What are the uniform qualifications for an initial VR service contract? A VR service contractor must meet all of the following uniform qualifications, as specifically detailed in the DVR RFQ for VR service contracts, to obtain any/all specific types of initial VR service contracts. Such qualifications shall include but not be limited to, qualifications regarding conformance to:

(1) Federal, state and local laws and DSHS regulations and policies;

(2) Accessibility;

(3) Safety and health;

(4) Liability insurance coverage;

(5) Having a system in place to report the effectiveness and efficiency of the provider's DVR services;

(6) Having a system in place to gather and report DVR customer satisfaction;

(7) DVR code of ethics and standards of practice;

(8) Having a complaint and dispute resolution process in place for DVR customers;

(9) Having current background checks in place for personnel serving DVR customers.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0300, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0310 How long does an initial VR service contract last? An initial VR service contract may be granted for a period of up to two years or for a duration as announced in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0310, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0320 Can an initial VR service contract be granted between RFQs? DVR may add VR service contractors between RFQs if DVR determines the contract is needed and the contractor meets all uniform VR service contract qualifications outlined in this chapter.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0320, filed 9/12/03, effective 10/13/03.]

SUBSEQUENT DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

WAC 388-892-0400 How does a contractor receive a subsequent VR service contract after completing their initial VR service contract? (1) To receive subsequent VR service contracts, a contractor must respond to each RFQ by submitting a proposal showing that they:

(a) Continue to meet all uniform VR service contract qualifications;

(b) Have met DVR's performance standards established in the prior VR service contract; and

(c) Meet the additional qualifications for each VR service to be offered.

(2) Contractors that have been granted an initial VR service contract between RFQs have two years from the effective date of their initial VR service contract to meet the additional qualifications outlined in this chapter. If the contractor fails to provide documentation of conformance to the additional qualifications within two years from the effective date of the initial contract, DVR may terminate the existing VR service contract with ten days notice to the contractor.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0400, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0410 What are the additional qualifications for VR service contracts? (1) In addition to the uniform VR service contract qualifications, additional contractor qualifications apply to each specific type of VR service contract.

(2) A separate RFQ is published for each specific type of VR service contract that outlines the additional contractor qualifications that are pertinent to that service.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0410, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0420 What are the additional qualifications for vocational evaluation services contracts? (1) Individuals or organizations providing brief vocational assessment and/or comprehensive vocational evaluation services must maintain conformance to all uniform VR service contract qualifications and be:

(a) Qualified as a certified vocational evaluator (CVE) by the commission on certification of work adjustment and vocational evaluation specialists (CCWAVES); or

(b) Accredited in comprehensive vocational evaluation services by CARF - the rehabilitation accreditation commission; or

(c) Hold a current certification as a certified rehabilitation counselor (CRC) by the commission on rehabilitation counselor certification (CRCC) and have successfully completed three graduate level courses, from an accredited college or university, in vocational evaluation; standardized assessment; psychological testing and measurement; or any combination of the above mentioned coursework.

(2) Individuals or organizations providing situational assessment services must maintain conformance to all uniform VR service contract qualifications, and be:

(a) Qualified as a certified vocational evaluator (CVE) by the commission on certification of work adjustment and vocational evaluation specialists (CCWAVES); or

(b) Accredited in employment planning services by CARF - the rehabilitation accreditation commission; or

(c) Licensed in employment services by the department of social and health services (DSHS)/mental health division (MHD); or

(d) Certified by the International Center for Clubhouse Development (ICCD); or

(e) Hold a current certification as a certified rehabilitation counselor (CRC) by the commission on rehabilitation counselor certification (CRCC) and have successfully completed three graduate level courses, from an accredited college or university, in vocational evaluation; standardized assessment; psychological testing and measurement; or any combination of the above mentioned coursework.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0420, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0430 What are the additional qualifications for job placement/retention services contracts? (1) Organizations that provide any job placement/retention service must maintain conformance to all uniform VR service contract qualifications.

(2) There are no additional qualifications for organizations that provide general job placement/retention services.

(3) Organizations that provide levels 1 or 2 specialized job placement/retention services must also be:

(a) Accredited in community employment services by CARF - the rehabilitation accreditation commission; or

(b) Licensed in employment services by the department of social and health services (DSHS)/mental health division (MHD); or

(c) Certified by the International Center for Clubhouse Development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0430, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0440 What are the additional qualifications for a transitional employment services contract? Organizations that provide transitional employment services contracts must:

(1) Maintain conformance to all uniform VR service contract qualifications; and

(2) Be certified by the International Center for Clubhouse Development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0440, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0450 How long does a subsequent VR service contract last? All DVR VR service contracts may be granted for a period of up to two years or for a duration as announced in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0450, filed 9/12/03, effective 10/13/03.]

DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS—GENERAL OPERATIONS

WAC 388-892-0500 What is DVR's payment system for VR service contracts? DVR establishes fixed fees for VR contract services as follows:

(1) DVR identifies geographic VR service delivery areas based on economic cost of living data.

(2) Every two years or on an interval as announced in the contract RFQ, with input received from the service providers, DVR will establish and publish a scheduled of fixed payment fee for each contracted VR service.

(3) All VR service contractors, within each geographic VR service delivery area, are paid the fixed payment fee for each contracted VR service.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0500, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0510 Can VR service contracts be denied or terminated? (1) DVR may decide not to accept a bid or an offer by a person or organization seeking to provide contracted VR services if the bid or offer does not meet minimum RFQ requirements. The DSHS bid protest procedures set forth in the request for qualifications shall be the exclusive administrative remedy for refusal to accept a bid or offer.

(2) VR service contracts may be terminated for cause or convenience at any time by DVR or the contractor in accordance with the terms of the contract. The contractor's administrative remedies shall be limited to those specified in the contract.

(3) Additionally, DVR may terminate all DVR individual case service delivery plans that are open with the contractor at the time their VR service contract is terminated. Termination provisions are outlined in the VR service contracts.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0510, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0520 What exceptions does DVR have to contract for vocational evaluation, job placement/retention and/or transitional employment services outside of these rules? DVR may define and contract for the purchase of any vocational rehabilitation services outside of these rules if necessary to meet the vocational rehabilitation needs of any individual or group of DVR customers.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0520, filed 9/12/03, effective 10/13/03.]