WSR 09-12-062
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed May 28, 2009, 2:48 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: In accordance with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, the department will be adjusting its payment rates for inpatient and outpatient hospital services. The department is amending language in sections in chapter 388-550 WAC and adding a new section in order to meet the legislature's targeted budget expenditure levels. Changes include: Adding language that the department may change the method for calculating the outpatient prospective payment system (OPPS) payments to achieve the legislature's targeted expenditure levels; adding language that incorporates into rule which hospitals are no longer exempted from the OPPS payment method and that the department pays all covered outpatient hospital services, except for those provided in critical access hospitals (CAHs), under the OPPS methodology; and implementing a prorated inpatient payment policy when a facility transfers a client to another facility under certain circumstances. The rules also remove "neonatal" from the list of diagnostic related group (DRG) service categories for claims that group to a medical, surgical, or burn DRG category, remove "prepay" from "retrospective prepay utilization review," and clarify that the department may perform these reviews. In addition, the rules eliminate outdated information, and update and clarify language, including removing language for "administrative day rate and swing bed rate" from WAC 388-550-4500 and placing it into a new section.

Citation of Existing Rules Affected by this Order: Amending WAC 388-550-3600, 388-550-3700, 388-550-4500, 388-550-7050, 388-550-7100, 388-550-7500 and 388-550-7600; and new sections WAC 388-550-4550 and 388-550-7450.

Statutory Authority for Adoption: RCW 74.04.050, 74.-04.057, 74.08.090, 74.09.500.

Other Authority: 2009-11 Omnibus Operating Budget (ESHB 1244).

Adopted under notice filed as WSR 09-08-118 on March 31, 2009.

A final cost-benefit analysis is available by contacting Carolyn Adams, P.O. Box 45510, Olympia, WA 98504-5510, phone (360) 725-1854, fax (360) 753-9152, e-mail adamscr@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 7, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 7, Repealed 0.

Date Adopted: May 28, 2009.

Susan N. Dreyfus
Secretary

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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~~)) (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit:

(a) Before July 1, 2009, to another acute care hospital or distinct unit; and

(b) On or after July 1, 2009, to one of the following:

(i) Another acute care hospital or distinct unit;

(ii) A skilled nursing facility (SNF);

(iii) An intermediate care facility (ICF);

(iv) Home care under the department's home health program;

(v) A long-term acute care facility (LTAC);

(vi) Hospice (facility-based or in the client's home);

(vii) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3000); or

(viii) A nursing facility certified under medicaid but not medicare.

(2) The department pays a hospital that transfers an emergency case to another acute care hospital, including an acute physical medicine and rehabilitation (acute PM&R) facility or distinct unit, an acute psychiatric facility or distinct unit, and a long-term acute care facility, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment based on a stable DRG; or

(b) A prorated DRG payment when the client's stay at the transferring hospital is less than the average length of stay (LOS) for the AP-DRG classification as determined by the department.

(3) The department pays a transferring hospital as follows:

(a) For dates of admission 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 LOS.

(b) For dates of admission on and 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 day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average LOS (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(4) 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 LOS data to determine the number of medically necessary days for a client's hospital stay.

(5) When a post-acute care hospital transfer occurs to one of the locations listed in subsection (1)(b)(ii) through (viii) of this section, the department pays the transferring hospital the lesser of:

(a) The appropriate DRG payment; or

(b) For dates of admission on and after July 1, 2009, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average length of stay (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(6) The department applies the outlier payment methodology if a transfer case qualifies:

(a) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(b) For dates of admission on or after August 1, 2007, as a high-cost outlier.

(7) The department does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(8) The department pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the department's maximum payment to a discharging hospital.

(9) 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.

(10) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (3) of this section.

(11) The transfer payment policy described in this section does not apply to claims grouped into AP-DRG classifications that are paid based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(12) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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 the 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 on or after 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~~)) claims from instate 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, and before August 1, 2007.)((~~.~~))

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.~~)) applicable DRG pymt ($15,000) or $33,000
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/((~~nonin-state~~))noninstate 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 a day outlier ((~~claims~~)) claim 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~~)) department's 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.

(a) 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~~)) Except as specified in (b) of this subsection, a claim that is grouped to a medical, surgical, or burn((~~, or neonatal~~)) DRG service category((~~,~~)) qualifies as a high outlier when the claim's estimated cost ((~~amount must be~~)) is 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.

(b) 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.

(c) The department ((~~performs~~)) may perform retrospective ((~~prepay~~)) utilization reviews 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 classifications assigned to the per diem payment method, that are in one of the ((~~following~~)) major ((~~services~~)) service categories in subsection (16)(a) through (d) of this section, qualify for ((~~determination to ascertain~~)) examination 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 an AP-DRG relative weight. A claim in a ((~~DRB~~)) DRG 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%

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
$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%

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
$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~~)) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the percentages of outlier adjustment factors described in this section.

(19) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

WAC 388-550-4500 Payment method—((~~Inpatient RCC rate, administrative day rate, hospital outpatient rate, and swing bed rate~~)) Ratio of costs-to-charges

(RCC). (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 outpa-~~

~~tient 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~~)) is defined in WAC 388-550-1050. The department uses:

(a) The RCC payment method to pay hospitals for hospital services that are exempt from the diagnosis related group (DRG), per diem, ambulatory payment classification (APC), maximum allowable fee schedule, and per case payment methods.

(b) The term "ratio of costs-to-charges" to refer to the factor (rate) applied to a hospital's allowed covered charges to determine estimated costs for medically necessary services.

(2) The department:

(a) Determines the payment due a hospital under the RCC payment method for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC rate by the allowed covered charges for medically necessary services.

(ii) Outpatient claims by multiplying the hospital's outpatient RCC rate by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection any:

(i) Client responsibility amount;

(ii) Third-party liability (TPL) amount; and

(iii) Other applicable payment program adjustment.

(c) Limits the RCC payment to the hospital's allowable usual and customary charges.

(3) For inpatient hospital dates of admission before August 1, 2007, the department uses the RCC payment method to pay for inpatient hospital services that are:

(a) Provided in a hospital located in the state of Washington (see WAC 388-550-4000 for out-of-state hospital payment methods and WAC 388-550-3900 for payment methods to designated bordering city and critical border hospitals);

(b) Provided in a diagnosis related group (DRG)-exempt hospital identified in WAC 388-550-4300; and

(c) Identified in WAC 388-550-4400 as DRG-exempt services (see WAC 388-550-4400 (2)(g), (h), and (k) for exceptions).

(4) For inpatient hospital dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay for:

(a) Organ transplant services identified in WAC 388-550-4400 (4)(h);

(b) High outlier qualifying claims (see WAC 388-550-3700 (14) and (15);

(c) Hospital services not covered under the LTAC per diem rate (see WAC 388-550-2596);

(d) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments (see WAC 388-550-4650(5)); and

(e) Any other hospital service identified and published by the department as being paid by the RCC payment method.

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection (4) of this section, except as provided in subsection (6) of this section.

(6) For hospitals paid under the certified public expenditure (CPE) payment method, the inpatient adjustment factor referred to in subsection (5) of this section does not apply, except to payments for repriced claims adjusted according to WAC 388-550-4670 (2)(a)(ii).

(7) The department calculates each instate and critical border hospital's RCC rate as follows. The department:

(a) Divides each hospital's allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) Excludes, prior to calculating the RCC rate, department nonallowed costs and nonallowed revenue, such as costs and revenues attributable to a change in ownership.

(c) 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. The "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) 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 the department. In the case 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.

(e) Limits a noncritical access hospital's RCC payment to one hundred percent of its allowed covered charges.

(f) Determines an RCC rate, when a hospital is formed as a result of a merger (refer to WAC 388-550-4200), by combining the previous hospital's medicare cost reports and following the process in (a) of this subsection. The department does not use partial year cost reports for this purpose.

(g) Determines a new instate hospital's RCC rate by calculating and using the average RCC rate for all current noncritical access hospitals located in Washington state. The department annually calculates a weighted average instate RCC rate by identifying all instate hospitals with specific RCC rates and dividing the department-determined total patient-related revenues associated with those costs.

(8) The department calculates each hospital's outpatient RCC rate annually.

(a) The department calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor (OAF).

(b) The department determines the weighted average instate hospital outpatient RCC rate by multiplying the instate weighted average inpatient RCC rate by the outpatient adjustment factor.

(9) The outpatient adjustment factor:

(a) Is the ratio between the outpatient and inpatient RCC payments, established in 1998 through negotiation with hospital providers;

(b) Is updated annually to adjust for cost and charge inflation;

(c) Must not exceed 1.0; and

(d) Is differentiated from the OPPS outpatient adjustment factor (defined in WAC 388-550-1050), and applies to hospitals exempt from OPPS.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 388-550-4550 Administrative day rate and swing bed day rate. (1) **Administrative day rate.** 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) The department uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1 of each year.

(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.

(2) **Swing bed day rate.** 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 pay a hospital the rate applicable to the acute inpatient level of care for those days of a hospital stay 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. These ancillary services 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.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

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~~)) a department-established component of the APC payment calculation 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 (NPR)" 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.

"Nationwide rate" see "national payment rate."

"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 (OPPS) conversion factor" ((~~means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation~~)) see "outpatient prospective payment system (OPPS) rate."

"Outpatient prospective payment system (OPPS) rate" 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~~)) code assigned to each medical procedure or service by the ((~~outpatient code editor (OCE) software~~)) department that contributes to the selection of a payment method.

"SI" see **"status indicator."**

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7100 OPPS—Exempt hospitals. (1) The department ((~~exempts~~)) exempted the following hospitals from the initial implementation of the 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)~~)) in 2004:

(a) Cancer hospitals;

((~~(2)~~)) (b) Critical access hospitals (CAHs);

((~~(3)~~)) (c) Free-standing psychiatric hospitals;

((~~(4)~~)) (d) Pediatric hospitals;

((~~(5)~~)) (e) Peer group A hospitals;

((~~(6)~~)) (f) Rehabilitation hospitals; and

((~~(7)~~)) (g) Veterans' and military hospitals.

(2) Effective for dates of service on and after July 1, 2009:

(a) Only CAHs remain exempt from OPPS; and

(b) The department pays all covered outpatient hospital services (except for those provided in CAHs), under the OPPS methodology.

(3) Refer to the applicable sections in chapter 388-550 WAC for outpatient payment methods used to pay hospitals exempted from OPPS (see subsections (1) and (2) of this section).

NEW SECTION

WAC 388-550-7450 OPPS budget target adjustor. (1) The outpatient prospective payment system (OPPS) budget target adjustor is a component of the ambulatory payment classification (APC) payment calculation. The budget target adjustor allows the department to reach but not exceed the established budget target. The same OPPS budget target adjustor value is applied to payments for all hospitals.

(2) The department calculates the OPPS budget target adjustor using:

(a) A payment system model developed by the department;

(b) The department's budget target;

(c) The department's outpatient fee schedule;

(d) Addendum B to 42 CFR Part 410 (medicare's hospital outpatient regulations and notices); and

(e) The wage index established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS budget target adjustor is set for the upcoming year.

(3) In response to direction from the legislature, the department may change the method for calculating the OPPS budget target adjustor to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

WAC 388-550-7500 OPPS ((~~conversion factor~~)) rate. (1) The department calculates ((~~the~~)) hospital-specific 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~~)) rates using:

(a) A payment method model established by the department; and

(b) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(2) The department may adjust OPPS rates to pay for graduate medical education (GME) costs. The department obtains the GME information from a hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(a) The hospital's "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year. In the case 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 hospital's OPPS rate.

(b) The department may not pay GME expenses for hospitals in specified categories, and hospitals that meet, or fail to meet, conditions specified in statute or WAC.

(3) In response to direction from the legislature, the department may change the method for calculating OPPS rates to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act.

AMENDATORY SECTION (Amending WSR 07-13-100, filed 6/20/07, effective 8/1/07)

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~~)) rate 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.

(4) In response to direction from the legislature, the department may change the method for calculating OPPS payments to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act.

WSR 09-12-063

PERMANENT RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Health and Recovery Services Administration)

[Filed May 28, 2009, 2:50 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: In accordance with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, the department will be adjusting its payment rates. The department is amending language in sections in chapter 388-550 WAC and WAC 388-502-0150 in order to meet the legislature's targeted budget expenditure levels for payment of hospital and hospital-related services provided to medical assistance clients. Changes include adding language to equalize rates paid for child birth, incorporating a prorated inpatient payment policy, adjusting rates to meet targeted inpatient and outpatient reductions, reducing the total period allowed for resubmission or modification of a claim other than a prescription drug or major trauma claim, incorporating into rule how per diem rates are determined for chronic pain services, and clarifying that WAC 388-550-4000 applies to both emergency and nonemergency services provided by out-of-state hospitals. In addition, the rules eliminate outdated information, and update and clarify language.

Citation of Existing Rules Affected by this Order: Amending WAC 388-502-0150, 388-550-2800, 388-550-3000, 388-550-3010, 388-550-3020, 388-550-3460, 388-550-3900, and 388-550-4000.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500.

Other Authority: 2009-11 Omnibus Operating Budget (ESHB 1244).

Adopted under notice filed as WSR 09-08-117 on March 31, 2009.

A final cost-benefit analysis is available by contacting Carolyn Adams, P.O. Box 45510, Olympia, WA 98504-5510, phone (360) 725-1854, fax (360) 753-9152, e-mail adamscr@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 8, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 8, Repealed 0.

Date Adopted: May 28, 2009.

Susan N. Dreyfus
Secretary

AMENDATORY SECTION (Amending WSR 00-14-067, filed 7/5/00, effective 8/5/00)

WAC 388-502-0150 Time limits for providers to bill ((~~MAA~~)) the department. Providers ((~~may~~)) must bill the **((~~medical assistance administration (MAA)~~))** department for covered services provided to eligible clients((~~.~~)) as follows:

(1) ((~~MAA~~)) The department requires providers to submit initial claims and adjust prior claims in a timely manner. ((~~MAA~~)) The department 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 and claims for major trauma services, see subsections (7) and (8) of this section; ((~~and~~))

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to ((~~MAA~~)) the department as described in ((~~MAA's~~)) the department's current published billing instructions.

(3) Providers must submit ((~~their~~)) the initial claim to ((~~MAA~~)) the department and have an internal control number (ICN) assigned by ((~~MAA~~)) the department within three hundred sixty-five calendar 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~~)) the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) ((~~MAA~~)) The department may grant exceptions to the time limit of three hundred sixty-five((~~-day time limit~~)) calendar days 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~~)) the department's satisfaction that there are other extenuating circumstances.

(5) ((~~MAA~~)) The department 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~~)) the department's billing limits.

(6) When a client is covered by both medicare and ((~~MAA~~)) medicaid, the provider must bill medicare for the service before billing ((~~medicaid~~)) the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill ((~~MAA~~)) the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, ((~~MAA~~)) the department 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~~)) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, 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 or a claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. ((~~MAA~~)) The department does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(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~~)) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) ((~~MAA~~)) The department 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~~)) the department 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~~)) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

AMENDATORY SECTION (Amending WSR 07-14-018, filed 6/22/07, effective 8/1/07)

WAC 388-550-2800 Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

Payment method used for medicaid and SCHIP 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]~~)) 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]~~)) 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~~)) Ratio of costs-to-charges (RCC) subject to cost settlement	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~~)) of costs after deducting any third party payment amount and any client responsibility amount.
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~~)) payment 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~~)) of 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) In response to direction from the legislature, the department may change any one or more payment methodologies outlined in chapter 388-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act. In response to this legislative direction, the department may calculate an adjustment factor (known as

an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the department and applied to existing inpatient hospital rates in order to meet targeted expenditure levels as directed by the legislature.

(b) The department will apply the inpatient adjustment factor when the department determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The department will apply any such inpatient adjustment factor to each affected rate in a proportional manner.

(3) 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)~~)) (4) The department's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the department would have paid using medicare payment principles.

((~~(4)~~)) (5) 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)~~)) (6) 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 requirements for a hospital to qualify for a DSH payment.

((~~(6)~~)) (7) Reports referred to in subsection ((~~(5)~~)) (6) 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)~~)) (8) The department requires hospitals to follow generally accepted accounting principles.

((~~(8)~~)) (9) 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)~~)) (10) 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)~~)) (11) 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)~~)) (12) 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.

AMENDATORY SECTION (Amending WSR 07-14-055, filed 6/28/07, effective 8/1/07)

WAC 388-550-3000 Payment method—DRG. (1) The department uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not limited to:

(a) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's specific DRG conversion factor. See WAC 388-550-3450. The total allowed amount also includes any high outlier amount calculated for claims. ((~~See WAC 388-550-3450 and 388-550-4600(4)~~)).

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific DRG conversion factor rate used in calculating the DRG payment.

(6) 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:

(i) Before July 1, 2009, from one acute care hospital or distinct unit to another acute care hospital or distinct unit; or

(ii) On and after July 1, 2009 from one acute care hospital or distinct unit to:

(A) Another acute care hospital or distinct unit;

(B) A skilled nursing facility (SNF);

(C) An intermediate care facility;

(D) Home care under the department's home health program;

(E) A long term acute care facility (LTAC);

(F) Hospice (facility-based or in the client's home);

(G) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3600); or

(H) A nursing facility certified under medicaid but not medicare.

(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)~~)) (7) For dates of admission on and after July 1, 2009, the department pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

(8) The department does not pay for a client's day(s) of absence from the hospital.

((~~(7)~~)) (9) 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)~~)) (10) The department applies to the payment for each claim all applicable ((~~claim payment~~)) adjustments for client responsibility, any third party liability, medicare, ((~~etc., to the payment~~)) and any other adjustments as determined by the department.

(11) The department pays hospitals in designated bordering cities for allowed covered services as described in WAC 388-550-3900.

(12) The department pays out-of-state hospitals for allowed covered services as described in WAC 388-550-4000.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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.

(2) The per diem payment method is effective for dates of admission before, on, and after August 1, 2007, for the following:

(a) Long term acute care (LTAC)((~~,~~));

(b) Hospital administrative day((~~,~~)) bed; and

(c) Hospital swing bed ((~~is effective for dates of admission before, and on and after, August 1, 2007~~)).

((~~(2)~~)) (3) 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~~)) uses the per diem payment method to pay for hospital stays that have insufficient data available to determine stable relative weights and other specialty services identified in WAC 388-550-3460.

((~~(3)~~)) (4) 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~~)) admission. 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)~~)) (5) The department ((~~has established~~)) establishes 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 for inpatient hospital stays that are exempt from the DRG payment method. See WAC 388-550-4300(6).

((~~(5)~~)) (6) The department's per diem payments to ((~~hospitals~~)) a hospital 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~~)) service 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.)

(f) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the per diem rate payments.

((~~(6)~~)) (7) The department does not pay for a client's day(s) of absence from the hospital.

((~~(7)~~)) (8) 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)~~)) (9) The department applies to the payment for each claim, all applicable ((~~claim payment~~)) adjustments for client responsibility, any third party liability, medicare, ((~~etc., to the payment~~)) and any other adjustments as determined by the department.

AMENDATORY SECTION (Amending WSR 07-14-051, 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 to the payment for each claim, all applicable ((~~claim payment~~)) adjustments for client responsibility, any third party liability, medicare, ((~~etc., to the payment~~)) and any other adjustments as determined by the department.

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific per case rate.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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~~)) specified in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as ((~~indicated~~)) specified in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as ((~~indicated~~)) specified in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as ((~~indicated~~)) specified in WAC 388-550-4500 as it existed before July 1, 2009 or WAC 388-550-4550 for these services effective for dates of admission on and after July 1, 2009.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diem((~~s~~)) rates for the services identified in subsection (1), except for the community psychiatric inpatient hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of community psychiatric inpatient services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates separate statewide standardized per diem rates for the following categories:

(i) Rehabilitation services—Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services—Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services—Chemically using pregnant (CUP) women program services are identified as any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the system. These claims include any statistical outliers. These statewide standardized amounts serve as the basis for calculating per diem rates for each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs. Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department adjusts the labor portion of the hospital-specific operating costs by the most ((~~currently available~~)) current hospital-specific medicare wage index established and published 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'~~)) service's 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~~)) current hospital-specific medicare wage index established and published by medicare ((~~that exists~~)) at the time of the medicaid rebasing((~~, as published by medicare~~)). (To determine the labor portion, the department uses the factor established by medicare multiplied by the statewide operating standardized amount.) 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 a 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 capi-

tal-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~~)) For burn cases, per diem rates are based on the average operating and capital cost per day ((~~of unstable burn claims at~~)) for Harborview Medical Center, which ((~~treats~~)) had 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.

(8) For dates of admission on and after August 1, 2007, for inpatient chronic pain services, the department establishes per diem rates based on allowed charges data that the department obtains from the hospital. The department determines the hospital per diem rate by identifying costs and dividing the total cost by the number of days associated with the cost.

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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~~)) The department uses the payment methods described in this section to pay bordering city hospitals and critical border hospitals for inpatient and outpatient claims. Bordering city hospitals and critical border hospitals are defined in WAC 388-550-1050.

(1) Bordering city hospitals—Inpatient hospital claim payment methods.

(a) For dates of admission before August 1, 2007, under the diagnosis related group (DRG) payment method:

(i) 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.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted 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.

(b) For dates of admission before August 1, 2007, under the ratio of costs-to-charges (RCC) payment method:

(i) The department calculates the RCC in accordance with WAC 388-550-4500.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department bases the RCC on the Washington instate average RCC.

(c) For dates of admission on and after August 1, 2007:

(i) The department calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the instate inpatient hospital rates without graduate medical education (GME) (excluding DWCC rates that are paid to instate critical access hospitals) for the DRG conversion factor, the per diem, per case, and RCC payment methods; and

(ii) The department pays the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(2) Bordering city hospitals—Outpatient hospital claim payment methods for allowed covered charges related to medically necessary services.

(a) For bordering city hospitals paid according to the outpatient prospective payment system (OPPS), refer to WAC 388-550-7000 through 388-550-7600. The department uses the following types of payment methods used in OPPS:

(i) Ambulatory payment classification (APC) method (the primary payment method for OPPS) (WAC 388-55-7200):

(A) Before August 1, 2007, the department determines the OPPS conversion factor using the methods described in WAC 388-550-7500.

(B) On and after August 1, 2007, the department pays using the lowest instate OPPS conversion factor.

(ii) OPPS maximum allowable fee schedule (WAC 388-550-7200).

(iii) Hospital outpatient RCC rate (WAC 388-550-4500).

(A) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(B) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(b) For bordering city hospitals exempt from OPPS, the department uses the following payment methods:

(i) Outpatient maximum allowable fee schedule (WAC 388-550-6000); and

(ii) Hospital outpatient RCC rate (WAC 388-550-4500).

(c) When the RCC payment method described in WAC 388-550-4500 is used to pay for outpatient services provided:

(i) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(ii) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(d) When the maximum allowable fee schedule method is used to pay for outpatient services provided, the department pays the lesser of the:

(i) Billed charges; or

(ii) Calculated payment amount.

(3) Designated critical border hospitals.

(a) Beginning August 1, 2007, the department designated certain qualifying hospitals located out-of-state as crit-

ical border hospitals. A designated critical border hospital must:

(i) Be a bordering city hospital as described in WAC 388-550-1050; and

(ii) Have submitted at least ten percent of the total nonemergency inpatient hospital claims that have been paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington state medicaid and state-administered programs. Nonemergency inpatient hospital claims are defined as those that do not include emergency room charges (revenue code 045X series).

(b) The department analyzes bordering city hospitals' base period claims data during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies or continues to qualify as a critical border hospital.

(4) Critical border hospitals—Inpatient hospital claim payment methods. The department pays inpatient critical border hospital claims with dates of services on and after August 1, 2007, as follows:

(a) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. The rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital.

(b) The department pays inpatient critical border hospital claims using the same payment methods and rates as for instate hospital claims, including DRG, RCC, per diem, outliers, and per case rate, subject to the following:

(i) Inpatient payment rates used to pay critical border university hospitals for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate university hospital;

(ii) Inpatient payment rates used to pay critical border Level 1 trauma centers for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate Level 1 trauma center; and

(iii) Inpatient payment rates used to pay critical border hospitals not listed in (A) and (B) of this subsection for inpatient hospital claims cannot exceed the highest corresponding instate inpatient payment rate for instate hospitals that are not designated as:

(A) Critical access hospitals (CAHs);

(B) University hospitals; or

(C) Level 1 trauma centers.

(5) Critical border hospitals—Outpatient hospital claim payment methods. The department pays outpatient critical border hospital claims with dates of services on and after August 1, 2007, using the same payment methods as for instate outpatient hospital claims, including the APC method using the hospital's OPPS conversion factor, maximum allowable fee schedule method, and the hospital outpatient RCC rate method (refer to WAC 388-550-7000 through 388-550-7600 and WAC 388-550-4500), subject to the following:

(a) Outpatient rates used to pay critical border university hospitals for outpatient claims cannot exceed the highest corresponding rate for an instate university hospital.

(b) Outpatient rates used to pay critical border Level 1 trauma centers for outpatient claims cannot exceed the highest corresponding rate for an instate Level 1 trauma center.

(c) Outpatient rates used to pay the critical border hospitals not listed in (i) and (ii) of this subsection for outpatient claims cannot exceed the highest corresponding rate for instate hospitals that are not designated as:

(i) Critical access hospitals (CAH);

(ii) University hospitals; or

(iii) Level 1 trauma centers.

(6) Critical border hospitals are eligible to receive payment for graduate medical education (GME). All other bordering city hospitals are not eligible to receive payment for GME.

(7) The department makes:

(a) Claim payment adjustments, including but not limited to, third party liability, medicare, and client responsibility; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

AMENDATORY SECTION (Amending WSR 07-14-051, filed 6/28/07, effective 8/1/07)

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:~~)) This section describes the payment methods the department uses to pay hospitals located out-of-state for providing services to eligible Washington state medical assistance clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 388-501-0175. Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC 388-550-3900.

(1) ((~~For dates of admission~~)) Emergency hospital services before August 1, 2007((~~, the department pays:~~)).

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals((~~,~~)) with dates of admission before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) ((~~The~~)) Weighted average of ratio of costs-to-charges (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals((~~,~~)) with the first date of service before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) ((~~The~~)) Weighted average of hospital outpatient ((~~hospital~~)) RCC rates for instate hospitals multiplied by the allowed covered charges for medically necessary services.

(2) ((~~For dates of admission~~)) Emergency hospital services on and after August 1, 2007((~~, the department pays:~~)).

(a) For 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.~~)) with dates of admission on and after August 1, 2007, 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)~~)) using the same methods used to pay instate hospitals:

(A) Diagnosis related group (DRG) (WAC 388-550-3000);

(B) Per diem (WAC 388-550-3010);

(C) DRG and per diem outliers (WAC 388-550-3700); and

(D) Ratio of costs-to-charges (RCC) (WAC 388-550-4500).

(ii) Pays ((~~a department designated critical border hospital according to WAC 388-550-3900~~)) using the lowest instate inpatient hospital rate corresponding to the payment method used in (a)(i) of this subsection.

(iii) Limits payment to out-of-state hospitals ((~~and bordering city hospitals that are noncritical border hospitals~~)) to the lesser of the:

(A) Billed charges; or ((~~the~~))

(B) Calculated payment amount.

(b) ((~~Pays~~)) For outpatient hospital claims for emergency services provided in out-of-state hospitals ((~~that are~~)) with dates of service on or after August 1, 2007, the department pays an out-of-state hospital using one or both of the following methods:

(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~~)) The maximum allowable fee schedule method described in WAC 388-550-6000, and limits payment when the maximum allowable fee schedule method is used to the lesser of the:

(A) Billed charges; or

(B) ((~~The instate average hospital outpatient rate times the allowed covered charges for medically necessary services~~)) Calculated payment amount.

(ii) The hospital outpatient RCC method described in WAC 388-550-4500. When using the RCC payment method, the department pays the lowest instate hospital outpatient RCC rate, excluding departmental weighted costs-to-charges (DWCC) rates that are paid to instate critical access hospitals.

(c) Out-of-state hospitals are not eligible to receive payment for graduate medical education (GME).

(3) The department makes:

(a) Claim payment adjustments, including but not limited to client responsibility, third party liability, and medicare; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

(4) Nonemergency services. The department does not pay for nonemergency hospital services provided to a medical assistance client((~~s~~)) in a hospital located out-of-state ((~~hospitals~~)) unless the ((~~facility~~)) hospital is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

(((~~i~~))) (a) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

(((~~ii~~))) (b) Authorized services are paid according to subsections (1) ((~~and~~)), (2), and (3) of this section.

(c) Bariatric surgery performed in a designated department-approved hospital is paid a per case rate and must be prior authorized by the department (see WAC 388-550-3020).

(((~~4) The department makes all applicable claim payment adjustments for clients responsibility, third party liability, medicare, etc., to claim payments.~~))

WSR 09-13-001
PERMANENT RULES
DEPARTMENT OF LICENSING

[Filed June 3, 2009, 2:14 p.m., effective July 4, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This will create licensing, education and definitions for licensed home inspectors to follow.

Statutory Authority for Adoption: RCW 18.280.050.

Other Authority: RCW 18.280. [18.28.060](6).

Adopted under notice filed as WSR 09-08-035 on March 25, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 25, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 25, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 3, 2009.

Ralph Osgood
Assistant Director

Chapter 308-408 WAC

DEFINITIONS

NEW SECTION

WAC 308-408-010 Words and terms. Words and terms used in these rules shall have the same meaning as each has under chapter 18.280 RCW unless otherwise clearly provided in these rules, or the context in which they are used in

these rules clearly indicates that they be given some other meaning.

(1) "Classroom" means training that takes place in a setting where individuals receiving training are assembled together and learn through lectures, study papers, class discussion, textbook study, or other means of organized formal education techniques, such as video, closed circuit, or other forms of electronic means.

(2) "Comment" means the act of stating one's observations clearly in the report.

(3) "Describe" means the act of stating one's observations clearly in the report.

(4) "Distance education" means a delivery method in which instruction takes place in other than a live classroom setting, the instructor and the student are in physically separate locations, and interactive instructional methods such as video-based instruction, computer conferencing, video conferencing, interactive audio, interactive computer software, correspondence or internet-based instruction are used.

(5) "Enter" means to physically go into an attic, crawlspace, or other area. Simply sticking one's head and shoulders into these areas is not entering.

(6) "Field training" is in addition to the one hundred twenty hours of classroom instruction and shall be done on actual inspection sites. Field training must include forty hours of instruction with a minimum of five actual complete home inspections done to the standards of practice under the supervision of an experienced inspector. The applicant will be required to complete written reports for each inspection and the supervisor will review the reports and certify that they are in full compliance with the standards of practice. The forty hours of supervised instruction will not include travel time to and from inspection, meals, and report writing time.

(7) "Interactive" means the course structure and technologies promote active student involvement with the course content, including the ability to:

(a) Access or bypass optional content, if applicable;

(b) Submit questions or answer test items, and receive direct feedback; and

(c) Communicate with the instructor and/or other students on an immediate or reasonably delayed basis.

Interactive instruction specifically excludes courses that only provide passive delivery of instructional content.

(8) "Passive" means there is no required or actual interaction or feedback between the student and instructor.

(9) "Preinspection agreement" is a written contract signed by the client that outlines the standards and work to be performed by the home inspector.

(10) "Preoffer consultation" is a verbal report that is limited in scope performed by a licensed home inspector. A preinspection agreement must be signed by the client and describe the limited scope of the consultation. This preoffer consultation is conducted only prior to mutual acceptance.

(11) "Readily accessible" means available for visual inspection without requiring moving personal property, dismantling, destructive measures, or any action that likely will involve risk to persons or property.

(12) "Record" means the act of stating one's observations clearly in the report.

(13) "Report" means the act of stating one's observations clearly in the report.

(14) "Standard home inspection" is a prelisting or presale written report that contains all or most of the components listed in the standards of practice. The components must be listed in the preinspection agreement. This standard home inspection report cannot be delivered verbally and must be in writing.

(15) "Technically exhaustive" is an investigation that involves dismantling, the extensive use of advanced techniques, measurements, instruments, testing, calculations or other means.

(16) "Traverse" means the act of physically moving through a crawlspace or attic or over the surface of a roof during an inspection when it is safe to do so.

Chapter 308-408A WAC

LICENSING

NEW SECTION

WAC 308-408A-010 Application for a license—Fingerprinting. Persons who have been convicted of a crime within ten years of application may be required to submit fingerprint identification on a form provided by the department prior to issuance of a license.

NEW SECTION

WAC 308-408A-020 Application process to take examination. This section does not apply to applicants for a home inspector's license who are actively licensed in another jurisdiction or were so licensed in the preceding six months in accordance with WAC 308-408A-040.

(1) Any person desiring to take an examination for a home inspector's license, except applicants who have received clock hours in another jurisdiction that have not been approved by the department, or applicants who are requesting substitution of clock hours per WAC 308-408A-050, shall telephone the testing service up to one day prior to the desired test date to schedule and pay for an examination by cashier's check, certified check, money order, credit card, debit card, e-checks, or money voucher to the testing service. On the day of the examination, the candidate shall submit a completed examination application that has been approved by the department to the testing service. This approval is valid for six months from the date of the approval letter. If the approval expires, the candidate must apply to be reapproved. Approval is granted upon successful completion of a one hundred twenty hour course in fundamentals of home inspection and proof of forty hours of field training approved by the department. The candidate must pass a course examination approved by the director. This course and the required field training must be completed within two years prior to applying for the home inspector's license examination.

(2) The candidate will be able to schedule an examination date up to one day prior to their desired test date. Candidates requesting a morning or afternoon test session will be scheduled immediately for an examination and will be provided with a registration number confirming their reserva-

tion. On the day of the examination, the candidate shall submit the verified examination application document to the testing service approved by the department.

(3) A candidate shall be assessed the full examination fee for any examination in which the candidate fails to provide two days' notice to the testing service for changing their examination date or for failing to arrive and take a scheduled examination at the time the examination is scheduled or rescheduled.

NEW SECTION

WAC 308-408A-030 Successful applicants must apply for license. Examination results are valid for one year only. Any person who has passed the examination for home inspector licensure must become licensed within one year from the date of such examination. Failure to comply with this provision will necessitate the taking and passing of another examination.

NEW SECTION

WAC 308-408A-040 Application for home inspector examination, licensed in another jurisdiction. (1) Any person applying for a home inspector examination who has been licensed and actively practices as a home inspector for two years in the last four years in another jurisdiction that meets or exceeds the requirements under chapter 18.280 RCW and has maintained his or her license in good standing is eligible to take the Washington state portion of the examination.

(2) Any person applying to take the examination under this section shall submit an examination application approved by the department and shall submit evidence of licensure in good standing in another jurisdiction by a license verification form completed by an administrative officer of the licensure authority in such jurisdiction.

(3) After the qualifications for the examination have been verified by the department the candidate shall contact the testing service up to one day prior to the desired test date to schedule and pay for an examination. Candidates requesting a morning or afternoon test session shall be scheduled immediately for an examination and will be provided with a registration number confirming their reservation. On the day of the examination, the candidate shall submit at the test site the verified examination application.

NEW SECTION

WAC 308-408A-050 Substitution of clock hours. (1) The director may allow for substitution of the clock hour requirements in RCW 18.280.070 if the individual is otherwise and similarly qualified by reason of completion of equivalent educational coursework in any institution of higher education or degree granting institution. Proof of a minimum of sixty hours of fundamentals of home inspection will qualify for a supplemental course to meet the one hundred twenty hour requirement.

(2) Individuals requesting approval of equivalent educational coursework shall submit a transcript of coursework completed from an institution of higher education or a degree granting institution together with an application for the license examination. The department may also require certification from an authorized representative of the institution of higher education or degree granting institution that the coursework satisfies the department's prescribed course content or curriculum and offered through classroom instruction for a given course(s).

NEW SECTION

WAC 308-408A-060 Grading of examinations. (1) To pass the home inspector examination a minimum scaled score of seventy is required on each portion. The home inspector examination shall consist of two portions:

(a) The national portion consisting of questions that test general home inspector practices; and

(b) The state portion consisting of questions that test on Washington laws and rules for home inspector licensing.

(2) A passing score for either portion of an examination shall be valid for a period not to exceed one year from the date of testing.

NEW SECTION

WAC 308-408A-070 Reexamination. An applicant who has failed the full or any portion of the examination or failed to appear for a scheduled examination may apply for reexamination, provided the required reexamination fee is submitted. An applicant who has failed the full or any portion of the examination or failed to appear for a scheduled examination may apply for reexamination by contacting the testing service to schedule and pay for an examination by cashier's check, certified check, money order, credit card, debit card, e-checks, or money voucher to the testing service approved by the department.

NEW SECTION

WAC 308-408A-080 Examination procedures. (1) Each applicant will be required to present one piece of positive identification which bears a photograph of the applicant. Failure to produce the required identification will result in the applicant being refused admission to the examination.

(2) Applicants will be required to refrain from:

(a) Talking to other examinees during the examination unless specifically directed or permitted to do so by a test monitor;

(b) Attempting to communicate or record any information;

(c) Using unauthorized materials during any portion of the examination;

(d) Removing test materials and/or notes from the testing room; and

(e) Disruptive behavior.

(3) Applicants who participate in any activity listed in subsection (2) of this section will be required to turn in their test materials to the test monitor and leave the examination site. Their opportunity to sit for the examination will be forfeited. Their answer sheet will be voided. A voided answer sheet will not be scored and the examination fee will not be refunded. A candidate must then reapply to take the examination.

(4) Any applicant who was removed from the testing site for any of the reasons listed in subsection (2) of this section will be required to submit a letter to the department requesting permission to retest and stating the circumstances of the event. After receipt of the applicant's letter, the department will review the proctor's report and the applicant's letter and may deny testing for up to one year.

NEW SECTION

WAC 308-408A-090 Home inspector fees. These fees are applicable to all original licenses, examination services, and fee generating services. The following fees shall be charged by professional licensing services of the department of licensing:

TITLE OF FEE	FEE
Home Inspector:	
Application/examination	$ 300
Reexamination	
Full	$ 300
National portion	$ 250
State portion	$ 125
Original license	$ 680
License renewal	$ 375
Late renewal with penalty	$ 435
Reinstatement penalty fine	$ 150
Course review	$ 75

NEW SECTION

WAC 308-408A-100 Home inspectors renewal—Expiration. The minimum requirements for a home inspector to be issued the renewal of a license are that the home inspector:

(1) Has furnished proof of successful completion of twenty-four hours in instruction in courses approved by the board.

(2) Submit a renewal fee.

(3) If the application for a renewal is not received by the director on or before the renewal date, a penalty fee as prescribed by the director by rule shall be paid.

(4) The license of any person whose license renewal fee is not received within one year from the date of expiration shall be canceled. This person may obtain a new license by satisfying the procedure and requirements as prescribed by the director by rule.

NEW SECTION

WAC 308-408A-105 Reinstatement of a canceled license for nonpayment of renewal fee. Any person desiring to be reinstated as a licensed home inspector within two years of cancellation may have their license reinstated by satisfying either of the following options:

(1) Submission of an application to the director providing proof of the following:

(a) Successful completion of twenty-four hours of approved home inspection coursework completed within one year preceding the application for reinstatement. A minimum of three clock hours must include a course(s) in Washington home inspector laws and regulations;

(b) Payment of all back renewal fees with penalty at the current rate; and

(c) Payment of reinstatement penalty fine of one hundred fifty dollars; or

(2) Satisfy the procedures and qualifications for initial licensing, including the following:

(a) Successful completion of the home inspection licensing examination; and

(b) Successful completion of the fundamentals of home inspection course pursuant to RCW 18.280.070(2); and

(c) Proof of up to forty hours of field training supervised by a licensed home inspector as required by RCW 18.280.070(3).

(3) Former licensees canceled for nonpayment of fees for periods in excess of two years will be required to satisfy the requirements of subsection (2) of this section.

NEW SECTION

WAC 308-408A-110 Continuing education clock hour requirements. A licensee shall submit to the department evidence of satisfactory completion of clock hours, pursuant to RCW 18.280.110, in the manner and on forms prescribed by the department.

(1) A licensee applying for renewal of a license shall submit evidence of completion of twenty-four hours of instruction in a course(s) approved by the board and commenced within twenty-four months of a licensee's renewal date.

(2) The twenty-four clock hours shall be satisfied by evidence of completion of approved real estate courses as defined in WAC 308-408B-040.

(3) Courses for continuing education clock hour credit shall be commenced after issuance of a first license.

(4) Approved courses may be repeated for continuing education credit in subsequent renewal periods.

(5) Clock hour credit for continuing education shall not be accepted if: The course is not approved pursuant to chapters 308-408B WAC and 18.280 RCW.

(6) Instructors shall not receive clock hour credit for teaching or course development.

Chapter 308-408B WAC

EDUCATION

HOME INSPECTOR COURSE APPROVAL

NEW SECTION

WAC 308-408B-010 Course approval required. (1) Any education provider or course developer must submit a course to the department for approval.

(2) Course approval by the department is required prior to the date on which the course is offered for clock hour credit.

(3) Each application for approval of a course shall be submitted to the department on the appropriate application form provided by the department.

(4) The director or designee shall approve, disapprove, or conditionally approve applications based upon criteria established by the board.

(5) Upon approval, disapproval or conditional approval, the applicant will be so advised in writing by the department. Notification of disapproval shall include the reasons therefor.

(6) Approval shall expire two years after the effective date of approval.

NEW SECTION

WAC 308-408B-020 Course titles reserved for prescribed curriculum courses. Any education provider desiring to offer any prescribed curriculum courses shall utilize the most recent course curriculum prescribed by the department, and shall include in its title the phrase "fundamentals of home inspection" if submitted for approval for clock hours. No other courses shall use this phrase in their titles.

NEW SECTION

WAC 308-408B-030 Application process for previously approved courses. (1) If there are no changes for a previously approved course in the course content or in the original course approval application or WAC 308-408B-040 affecting the topic areas or criteria for approval, the course will be approved upon receipt of a course renewal application and payment of the required fee for one renewal cycle only.

(2) If there are changes in course content or in the original course approval application for a previously approved course, other than updating for changes required by WAC 308-408B-050, the application will not be processed as a renewal, and will require completion of a course approval application and payment of the required fee.

(3) If a course renewal application or a course approval application is submitted at least thirty days prior to the current course expiration date, the previous course approval shall remain in effect until action is taken by the director.

NEW SECTION

WAC 308-408B-040 General requirements for course approval. Courses shall meet one of the following requirements:

(1) Be offered by a private entity; or

(2) Be offered by a tax-supported, public technical or community college or other institution of higher learning that offers college credits; or

(3) Be offered by the Washington home inspector board; and

(4) Have a minimum of one hundred twenty hours of coursework or instruction for the student for prelicense; or

(5) Have a minimum of two hours of coursework or instruction for the student for continuing education. A clock-hour is a period of fifty minutes of actual instruction; and

(6) Provide practical information related to the practice of home inspection in any of the following home inspection topic areas:

(a) Department prescribed curricula for prelicense: Fundamentals of home inspection.

(b) Continuing education:

(i) Communications;

(ii) Structures;

(iii) Plumbing;

(iv) Electrical;

(v) Heating;

(vi) Ventilation;

(vii) Air conditioning;

(viii) Law and business administration;

(ix) Current trends and issues;

(x) Exteriors;

(xi) Interiors;

(xii) Consumer protection;

(xiii) Report writing; and

(xiv) Environmental conditions or hazardous materials.

(7) Be under the supervision of an instructor, who shall, at a minimum, be available to respond to specific questions from students;

(8) The following types of courses will not be approved for clock hours:

(a) Mechanical office and business skills, such as, keyboarding, speed-reading, memory improvement, and grammar;

(b) Standardized software programs such as word processing, e-mail, spreadsheets or data bases; an example: A course specific to the reporting system necessary to deliver a home inspection would be acceptable, but a course teaching how to use a computer would not be acceptable;

(c) Orientation courses for licensees, such as those offered by trade associations;

(d) Personal and sales motivation courses or sales meetings held in conjunction with a licensee's general business;

(e) Courses that are designed or developed to serve other professions, unless each component of the curriculum and content specifically shows how a home inspector licensee can utilize the information in the practice of home inspection;

(f) Personal finance, etiquette, or motivational type courses;

(g) Courses that are designed to promote or offer to sell specific products or services to home inspector licensees such as warranty programs, client/customer data base systems, software programs or other devices. Services or products can be offered during nonclock hour time, such as breaks or lunch time. Letterhead, logos, company names or other similar markings by itself, on course material are not considered promotional;

(h) Clock hours will not be awarded for any course time devoted to meals or transportation.

(9) Prelicense courses which are submitted for approval shall include a comprehensive examination(s) and answer key(s) of no fewer than two hundred questions, and a requirement of passing course grade of at least seventy percent; essay question examination keys shall identify the material to be tested and the points assigned for each question; an examination is not required for continuing education courses;

(10) Include textbook or instructional materials approved by the director, which shall be kept accurate and current;

(11) Not have a title which misleads the public as to the subject matter of the course;

(12) The provider's course application shall identify learning objectives and demonstrate how these are related to the practice of home inspection.

NEW SECTION

WAC 308-408B-050 Changes and updates in approved courses. Course materials shall be updated no later than thirty days after the effective date of a change in federal, state, or local statutes or rules. Course materials shall also be updated no later than thirty days after changes in procedures or other revisions to the practice of home inspection which affect the validity or accuracy of the course material or instruction.

NEW SECTION

WAC 308-408B-060 Certificate of course completion. Each education provider must issue a certificate of course completion within thirty days to students who have satisfactorily completed the course requirements. The certificate shall include the following information:

(1) Student's name;

(2) School's name;

(3) The course commencement date and completion date;

(4) Course title;

(5) Clock hours for the course;

(6) School administrator's signature;

(7) Course identification number issued by the department;

(8) Instructor name; and

(9) Completion of a required examination, if applicable.

NEW SECTION

WAC 308-408B-070 Courses offered in a symposium or conference format. (1) Approved schools offering courses in a symposium or conference format with two or more modules of independent instruction may issue certificates of course completion for fewer clock hours than approved by the department on their original course approval application; and

(2) Students must complete a minimum of two clock hours of instruction to receive clock hour credit.

NEW SECTION

WAC 308-408B-080 Disciplinary action—Procedures—Investigation. (1) The department shall have the authority on its own motion or upon complaint made to it to investigate or audit any course to determine compliance with chapter 18.280 RCW and with the rules and regulations of this chapter.

(2) Complaints concerning approved courses should be made in writing to the department and contain the following information when appropriate:

(a) The complainant's name, address, and telephone number;

(b) School name, address, and telephone number;

(c) Instructor(s) name;

(d) Nature of complaint and facts detailing dates of attendance, termination date, date of occurrence, names, addresses and positions of school officials contacted, and any other pertinent information;

(e) An explanation of what efforts if any, have been taken to resolve the problem with the school;

(f) Copies of pertinent documents, publications, and advertisements.

NEW SECTION

WAC 308-408B-090 Grounds for denial or withdrawal of course approval. Course approval may be denied or withdrawn if the instructor or any owner, administrator or affiliated representative of a school, or a course provider or developer:

(1) Submits a false or incomplete course application or any other information required to be submitted to the department;

(2) Includes in its title the phrase "fundamentals of home inspection" if the course was not submitted for approval of clock hours pursuant to WAC 308-408B-020;

(3) If the title of the course misleads the public and/or licensees as to the subject matter of the course;

(4) If course materials are not updated within thirty days of the effective date of a change in the statute or rules;

(5) If course content or material changes are not submitted to the department for approval prior to the date of using the changed course content;

(6) Failed to meet the requirements under WAC 308-408B-040 and 308-408B-120;

(7) If a course or prescribed curriculum was approved through the mistake or inadvertence of the director.

NEW SECTION

WAC 308-408B-100 Hearing procedure. Upon notice of course denial or disapproval or withdrawal of course approval, a person is entitled to a hearing conducted in accordance with the Administrative Procedure Act, chapter 34.05 RCW, and the provisions of WAC 308-408B-040. To exercise the right to a hearing under this section, a person must request a hearing within twenty days after receipt of the notice of denial, disapproval or withdrawal of course approval. Any person aggrieved by a final decision of the director or authorized representative of the director is entitled to judicial review under the provisions of the Administrative Procedure Act, chapter 34.05 RCW.

NEW SECTION

WAC 308-408B-110 Record retention. (1) Each school shall maintain for a minimum of five years each student's record;

(2) A "student record" shall include:

(a) The name, address, and telephone number of the school;

(b) Full name, address, and telephone number of the student;

(c) Beginning and ending dates of attendance;

(d) Clock hour courses completed and examination results.

(3) Each school shall provide a copy of a student's record to the student or the department upon request.

NEW SECTION

WAC 308-408B-120 Distance education delivery method approval required. Applicants are required to submit an application for each separate distance education delivery method for which they propose to offer approved courses for clock hours. When submitting a distance education delivery method application, the following minimum criteria must be provided by the applicant:

(1) Specify the course learning objectives for each learning unit and clearly demonstrate that the learning objectives cover the subject matter and how these relate to the practice of home inspection. Objectives must be specific to ensure that all content is covered adequately to ensure mastery;

(2) Demonstrate how mastery of the material is provided by:

(a) Dividing the material into major learning units, each of which divides the material into modules of instruction;

(b) Specifying learning objectives for each learning unit or module of instruction. Learning objectives must be comprehensive enough to ensure that if all the objectives are met, the entire content of the course will be mastered;

(c) Specifying an objective, quantitative criterion for mastering, used for each learning objective and provide a structured learning method designed to enable students to attain each objective.

(3) Demonstrate that the course includes the same or reasonably similar informational content as a course that would otherwise qualify for the requisite number of clock hours of classroom-based instruction and how the provider will know that the student completed the required number of clock hours;

(4) Describe consistent and regular interactive events appropriate to the delivery method. The interactive elements must be designed to promote student involvement in the learning process, and must directly support the student's achievement of the course learning objectives. The application must identify the interactive events included in the course and specify how the interactive events contribute to achievement of the stated learning objectives;

(5) Demonstrate how the course provides a mechanism of individual remediation to correct any deficiencies identified during the instruction and assessment process;

(6) Measure, at regular intervals, the student's progress toward completion of the master requirement for each learning unit or module. In the case of computer-based instruction, the course software must include automatic shutdown after a period of inactivity;

(7) Demonstrate that instructors are available to answer questions regarding course content at reasonable times and by reasonable means, including in-person contact, individual and conference telephone calls, e-mail and fax;

(8) Demonstrate how reasonable security will be provided to ensure that the student who receives credit for the course is the student who enrolled in and completed the course. Both the approved school and the student must certify in writing that the student has completed the course, and the required number of clock hours;

(9) Provide a complete description of any hardware, software, or other technology to be used by the provider and needed by the student to effectively engage in the delivery and completion of the course material and an assessment of the availability and adequacy of the equipment, software or other technologies to the achievement of the course's instructional claims;

(10) Provide an orientation session with the instructor or an affiliated representative of an approved school. Mechanisms must be clearly in place which allow students an early orientation to discuss course specifics;

(11) Demonstrate how the provider determined the number of clock hours requested in the distance education delivery method approval application; and

(12) Provide with each distance education delivery method approval application a copy of a course evaluation form. The provider must provide each student with the mandatory evaluation form and retain the completed form in the school records as required under WAC 308-408B-110.

WSR 09-13-018
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed June 5, 2009, 11:28 a.m., effective July 6, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule making modifies WAC 296-15-221 for simplification and clarity. References to self-insured assessments have been moved to new sections, leaving the content of WAC 296-15-221 to solely address reporting requirements. The rule making creates four new sections to specifically address self-insured assessments, including the administrative assessment, the second injury fund assessment, the insolvency trust fund assessment, and the supplemental pension fund and asbestosis fund assessments.

The new section relating to the self-insurance second injury fund assessment also includes new requirements for experience rating 50% of all self-insured employers' second injury fund assessments.

Citation of Existing Rules Affected by this Order: Amending WAC 296-15-221 Self-insurers' reporting requirements.

Statutory Authority for Adoption: RCW 51.14.077, 51.14.150, 51.14.160, 51.44.040, 51.44.070, and 51.44.150.

Adopted under notice filed as WSR 09-09-113 on April 21, 2009.

Changes Other than Editing from Proposed to Adopted Version: The supplemental pension fund (SPF) was inaccurately referred to in the proposal as the "supplemental pension reimbursement fund (SPRF)." The department modified the rules to correct this error.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal

Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 4, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 4, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 5, 2009.

Judy Schurke
Director

AMENDATORY SECTION (Amending WSR 99-23-107, filed 11/17/99, effective 12/27/99)

WAC 296-15-221 Self-insurers' reporting requirements. (1) **What information must self-insurers report to the department?** Each self-insurer must provide the department:

(a) The name, title, address and phone number of the single contact person who is the liaison with the department in all self-insurance matters. This contact will be sent all department correspondence and is responsible for forwarding information to appropriate parties for timely action.

(b) A copy of its current policy of applying sick leave, health and welfare benefits or any other compensation in conjunction with, or as a substitute for, time loss benefits.

(2) **When must self-insurers notify the department of business status changes?** Self-insurers must notify the department in writing:

(a) Immediately, of any plans to:

(i) Cease business entirely or cease business in Washington; or

(ii) Dispose of controlling financial interest of the original self-insurer. The self-insurer must surrender its certificate for cancellation if requested by the department.

(b) Within thirty days, of any:

(i) Amendment(s) or modification(s) to the self-insurer's articles, charter or agreement of incorporation, association, copartnership or sole proprietorship which will materially change the business identity or structure originally certified.

(A) The department may require additional documentation.

(B) If the self-insurer becomes a subsidiary to another firm, the parent must provide the department with its written guarantee on L&I form F207-040-001 to assume responsibility for all workers' compensation liabilities of the subsidiary if the subsidiary defaults on its liabilities. See WAC 296-15-021 for additional information.

(ii) Separation (for example, divestiture or spinoff) of any part of the original self-insurer.

(A) The original self-insurer remains responsible for claims liability of the separated part up to the date of separation unless the department approves an alternative.

(B) If the separating part wishes to continue being self ((~~insurance~~))-insured, it must submit an application for self-insurance certification (L&I Form F207-001-000) to the department at least thirty days before separation ((~~and requested certification~~)).

(C) If certification cannot be granted before separation, industrial insurance coverage must be purchased from the state fund ((~~from~~)) effective the date of separation.

(iii) ((~~Relocating, adding or closing~~)) Relocation, addition or closure of physical locations.

(3) **When must self-insurers notify the department of administrative changes?** A self-insurer must notify the department in writing within ten days, of any change to its:

(a) Single contact person who is the liaison with the department in all self-insurance matters. The self-insurer must include the contact's title, address and phone number.

(b) Contract with a service organization((~~/~~)) or third party administrator independent of the self-insurer which will participate in the self-insurer's responsibilities. The self-insurer must submit a copy of the new or updated service contract. See WAC 296-15-021 for additional information.

(c) Administrator of its workers' compensation program, if the self-insurer is self administered instead of contracting with a service organization or third party administrator.

(4) **What reports must self-insurers submit to the department?** Each self-insurer must submit:

(a) Complete and accurate quarterly reports summarizing worker hours and claim costs paid the previous quarter. Self-insurers must use a form substantially similar to the preprinted ((~~SIQTRR~~)) Quarterly Report for Self-Insured Business, L&I form F207-006-000, form sent by the department. ((~~Payment is due the 30th day after receiving the preprinted report from the department.~~)) This report is the basis for determining the administrative, second injury fund, supplemental pension, asbestosis and insolvency trust assessments. Payment is due by the date specified on the preprinted report sent by the department.

(i) ((~~Administrative, second injury fund and insolvency trust assessments are based on a self insurer's total claim costs. Total~~)) Worker hours must be reported as defined in chapter 296-17 WAC General reporting rules, audit and recordkeeping, rates and rating system for Washington workers' compensation insurance.

(ii) Claim costs ((~~during a quarter~~)) include, but are not limited to:

(A) Time loss compensation. Include the amount of time loss the worker would have been entitled to if kept on full salary.

(B) Permanent partial disability (PPD) awards.

(C) Medical bills.

(D) Prescriptions.

(E) Medical appliances.

(F) Independent medical examinations and/or consultations.

(G) Loss of earning power.

(H) Travel expenses for treatment or rehabilitation.

(I) Vocational rehabilitation expenses.

(J) Penalties paid to injured workers.

(K) Interest on board orders.

((~~(ii) Supplemental pension (SPRF) and asbestosis fund assessments are based on a self insurer's worker hours. Worker hours must be reported as defined in chapter 296-17 WAC General reporting rules, classifications, audit and recordkeeping, rates and rating system for Washington workers' compensation insurance.~~

~~Note: Self insurers may request reimbursement quarterly from SPRF as authorized under Title 51 RCW. Use a form substantially similar to L&I form F207-011-000 or F207-011-222, if there is Social Security offset.~~

~~(iii) The administrative assessment covers department administrative costs, including expenses of other department divisions, the University of Washington environmental research facility, the board of industrial insurance appeals and other general administrative costs. The administrative assessment rate is applied to a self insurer's total claim costs.~~

~~(A) The administrative assessment rate is based on the actual costs of the previous fiscal year and the anticipated costs of the upcoming fiscal year. Employers certified after the fiscal year used for calculation will be assessed at a rate that does not include prior fiscal periods.~~

~~(B) Employers no longer self insured must pay an adjusted assessment rate until one year after all self insurance liabilities and responsibilities are terminated.~~

~~(C) The minimum quarterly assessment is twenty-five dollars.~~

~~(iv) The second injury fund rate will be based on anticipated second injury fund costs.~~

~~(A) Self insurers' contributions to the second injury fund will be recorded in the self insurers' account, separate from the state fund account.~~

~~(B) The self insurers' second injury fund must maintain a two hundred thousand dollar minimum balance.~~

~~(v) Insolvency trust members (all self insurers except school districts, cities and counties) are also assessed to cover claim payments made by the department on behalf of insolvent self insurers. School districts, cities and counties are exempt from and are not covered by this insolvency trust. Any interest earned on the assessment becomes part of the insolvency trust fund. The insolvency assessment rate is applied to a self insurer's total claim costs. Failure to pay an insolvency trust assessment is grounds for withdrawal of certification. Members who voluntarily surrender certification must continue to pay this assessment for three years after the date of surrender.~~))

(b) A complete and accurate annual report of all claim costs paid for each year of liability with an estimate of future claim costs. The self-insurer must use a form substantially similar to the Annual Report for Self-Insured Businesses (SIF-7), L&I form F207-007-000. This report is due March 1 ((~~and is the basis for~~)) of each year. The department((~~'s~~)) uses this for the annual determination of each self-insurer's surety requirement.

(c) A fully audited financial statement within six months after the end of the self-insurer's fiscal year. This report demonstrates the self-insurer's continued ability to provide benefits and pay assessments as required. The department will consider a written request for filing time extension.

(i) This statement must be prepared by a certified public accountant.

(ii) A self-insurer with a parental guarantee may submit the parent's fully audited financial statement if the parent's audited statement includes the financial condition of all subsidiaries, including the self-insurer.

(iii) A political subdivision of the state may submit a state auditor's report if it includes the self-insurer's audited financial statement. If the state auditor does not audit the self-insurer annually, ((~~political subdivisions~~)) the self-insurer must submit financial statements prepared internally for ((~~the years between~~)) any year a report((~~s~~)) by the state auditor is not available.

NEW SECTION

WAC 296-15-223 Self-insurance administrative assessment. (1) The administrative assessment covers the department's administrative costs, including direct and indirect expenses of each department division, the University of Washington environmental research facility, and the board of industrial insurance appeals. The assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(2) The administrative assessment rate is determined annually for each fiscal year. Each self-insured employer uses one of three rates:

(a) The base administrative rate is based on the actual costs of the previous fiscal year and the anticipated costs of the upcoming fiscal year. This rate is used by any active self-insured employer certified after the fiscal year used for calculation.

(b) The adjusted administrative assessment rate includes the base rate with adjustments for over or under collections from prior periods. This rate is used by any active self-insured employer certified during or prior to the fiscal year used for calculation.

(c) Employers who have voluntarily surrendered their self-insurance certificate must pay the inactive rate until one year after all self-insurance liabilities and responsibilities are terminated. Usually, administrative assessment payments for inactive self-insurers can stop after reporting total claims costs of zero dollars for four consecutive quarters. Payments may again be due if any future costs are reported.

(3) The total administrative assessment due each quarter is calculated by multiplying the self-insurer's rate by their total claims costs during that quarter.

(4) The minimum quarterly administrative assessment for all self-insured employers is twenty-five dollars, unless the self-insurer is not required to make payment (see subsection (2)(c) of this section).

NEW SECTION

WAC 296-15-225 Self-insurance second injury fund assessment. (1) The second injury fund assessment is based on anticipated second injury fund costs. The fund is used to relieve employers' costs related to pensions that result from the combined effects of the industrial injury and another prior injury, preferred worker claims, and job modifications. Fifty percent of all self-insurers' second injury fund assessment rate is based on the self-insurers' estimated expenditures from the second injury fund. The other fifty percent is experience

rated based on each self-insured employer's actual expenditures from the fund. See RCW 51.44.040 for more information about experience rating. The second injury fund assessment is paid by active and inactive self-insurers quarterly at the same time a self-insurer submits its quarterly report.

(2) Self-insurers' relief from and contributions to the second injury fund will be recorded in an account separate from the state fund account. The self-insurers' second injury fund must maintain a two hundred thousand dollar minimum balance.

(3) The second injury fund assessment rate is determined annually for each fiscal year.

(a) Each self-insurer uses one of two rates for the fifty percent of the second injury fund assessment rate that is based on total estimated expenditures.

(i) The base second injury fund assessment rate is based on fifty percent of the estimated costs for the coming fiscal year. This rate is used by any self-insured employer certified after the fiscal year used for calculation.

(ii) The adjusted second injury fund assessment rate includes the base rate with adjustments for over or under collections from prior periods. This rate is used by any self-insured employer certified during or prior to the fiscal year used for calculation. This rate is also used by any self-insurer who has voluntarily surrendered its self-insurance certificate.

(b) The second fifty percent of the second injury fund assessment is experience rated for each self-insurer based on each self-insurer's actual use of the second injury fund in the previous three fiscal years.

Note: The department may estimate claims cost data when actual data from an employer has yet to be provided.

Each self-insurer's experience rating will be calculated using the following steps:

(i)
$$\frac{\text{A self-insurer's total second injury fund expenditures for the previous three fiscal years}}{\text{Total second injury fund expenditures for all self-insurers in the previous three fiscal years}}$$

(ii)
$$\frac{\text{A self-insurer's self-insured claims costs for the previous three fiscal years}}{\text{Total self-insured claims costs for all self-insurers in the previous three fiscal years}}$$

(iii)
$$\frac{\text{[The result of (b)(i) of this subsection] + [The result of (b)(ii) of this subsection]}}{2}$$

(iv)
$$\frac{\text{The result of (b)(iii) of this subsection}}{\text{The result of (b)(ii) of this subsection}} = \text{the self-insurer's experience rate}$$

(c) Each self-insurer's final combined second injury fund assessment rate is calculated using the following formula:

(i) 1/2 x [the appropriate base or adjusted rate]

(ii) [The result of (c)(i) of this subsection] x [the self-insurer's experience rate]

(iii) [The result of (c)(i) of this subsection] + [The result of subsection (c)(ii) of this subsection] = the final combined second injury fund assessment rate.

(4) The total second injury fund assessment due each quarter is calculated by multiplying the self-insurer's final combined second injury fund assessment rate by the self-insurer's total claims costs during that quarter.

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 296-15-227 Self-insurance insolvency trust fund assessment. (1) The insolvency trust fund assessment is paid by all insolvency trust members to cover claim payments made by the department on behalf of insolvent self-insurers. The assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) Self-insured school districts, cities, and counties are exempt from and are not covered by this insolvency trust. These self-insurers are not liable for the insolvency trust fund assessment.

(b) Any interest earned on insolvency trust fund assessments paid by self-insurers will be added to the balance of the insolvency trust fund.

(c) Failure to pay an insolvency trust fund assessment is grounds for withdrawal of self-insurance certification.

(2) The insolvency trust fund assessment rate is determined annually for each fiscal year.

(3) Insolvency trust members who voluntarily surrender their self-insurance certification must continue to pay this assessment for three years after the date of surrender.

(4) The total insolvency trust fund assessment due each quarter is calculated by multiplying the insolvency trust fund assessment rate by an insolvency trust member's total claims costs during that quarter.

NEW SECTION

WAC 296-15-229 Self-insurance supplemental pension fund (SPF) and asbestosis fund assessments. (1) The SPF relieves employers from cost-of-living increases on benefits paid to workers. The SPF assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) The SPF rate is determined annually for each calendar year.

(b) The total SPF assessment due each quarter is calculated by multiplying the SPF assessment rate by a self-insurer's worker hours during that quarter.

(c) One-half of the SPF assessment may be withheld from employee wages or salaries.

(d) Self-insurers may request reimbursement from the SPF quarterly, as authorized under Title 51 RCW, or they may deduct eligible SPF reimbursement amounts directly from their quarterly SPF assessment. If requesting reimbursement from the SPF quarterly, the self-insurer must use a form substantially similar to L&I form F207-011-000 or, if there is Social Security offset, L&I form F207-011-222.

(2) The asbestosis fund provides benefits to workers who have been diagnosed with an industrially related asbestosis condition during the often lengthy process of determining the liable employer. The asbestosis fund assessment is paid quarterly at the same time a self-insurer submits its quarterly report.

(a) The asbestosis fund assessment rate is determined annually for each calendar year.

(b) The total asbestosis fund assessment due each quarter is calculated by multiplying the asbestosis fund assessment rate by a self-insurer's worker hours during that quarter.

(c) One-half of the asbestosis fund assessment may be withheld from employee wages or salaries.

WSR 09-13-031
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-111—Filed June 9, 2009, 11:29 a.m., effective July 10, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The purpose of this rule change is to minimize confusion and avoid possible mistakes by license vendors. Prior to this rule change, subsection (4) authorized an individual who has a Washington hunting license from a preceding year to show the license and purchase a subsequent license even if the initial license was not issued in compliance with the hunter education training requirements. This proposal will allow individuals to purchase a Washington hunting license only if they have a hunter education certificate or are identified as previous Washington hunters in the current license data system.

Citation of Existing Rules Affected by this Order: Amending WAC 232-12-227.

Statutory Authority for Adoption: RCW 77.12.047.

Adopted under notice filed as WSR 09-03-111 on January 21, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 5, 2009.

Miranda Wecker, Chair
Fish and Wildlife Commission

AMENDATORY SECTION (Amending WSR 97-22-003, filed 10/23/97, effective 11/23/97)

WAC 232-12-227 Hunter education training program requirements. (1) The director may designate a state coordinator for the purpose of administering the hunter education program. The state coordinator shall be responsible for the certification of volunteer instructors and the development of instructional materials, training aids, operating policies and procedures necessary to comply with the provisions of this section and RCW 77.32.155.

(2) It is unlawful for any person born after January 1, 1972, to obtain an initial hunting license in the state of Washington without having completed a department-approved course involving at least ten hours of instruction in conservation, safety and sportsmanship.

(3) Upon satisfactory completion of these requirements, each student shall be issued a certificate of accreditation signed by an authorized instructor or the state coordinator.

(4) It is unlawful for a license dealer to issue a hunting license for a person born after January 1, 1972, unless a hunter education certificate ((~~or a Washington hunting license for a preceding year issued to said person~~)) is presented at the time of purchase. This subsection does not apply to individuals listed in the department's licensing data base system with a valid hunter education certificate number.

WSR 09-13-037
PERMANENT RULES
LIQUOR CONTROL BOARD

[Filed June 10, 2009, 11:07 a.m., effective July 11, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 314-29-010(2) is amended to clarify the language. Liquor licensees will have no question as to what action will be taken by the liquor control board if they don't respond to an administrative violation notice within the twenty day timeline.

Citation of Existing Rules Affected by this Order: Amending WAC 314-29-010(2).

Statutory Authority for Adoption: RCW 66.08.030.

Adopted under notice filed as WSR 09-09-128 on April 22, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 10, 2009.

Lorraine Lee
Chairman

AMENDATORY SECTION (Amending WSR 08-17-056, filed 8/15/08, effective 9/15/08)

WAC 314-29-010 What options does a licensee or permit holder have once he/she receives a notice of an administrative violation? (1) A licensee or a mandatory alcohol server training permit holder has twenty days from receipt of the notice to:

(a) Accept the recommended penalty; or

(b) Request a settlement conference in writing; or

(c) Request an administrative hearing in writing.

A response must be submitted on a form provided by the agency.

(2) **What happens if a licensee or mandatory alcohol server training permit holder does not respond to the administrative violation notice within twenty days?** If a licensee or permit holder does not respond to the administrative violation notice within twenty days, the recommended suspension penalty will go into effect.

(3) **What are the procedures when a licensee or mandatory alcohol server training permit holder requests a settlement conference?**

(a) If the licensee or permit holder requests a settlement conference, the hearing examiner or captain will contact the licensee or permit holder to discuss the violation.

(b) Both the licensee or permit holder and the hearing examiner or captain will discuss the circumstances surrounding the charge, the recommended penalty, and any aggravating or mitigating factors.

(c) If a compromise is reached, the hearing examiner or captain will prepare a compromise settlement agreement. The hearing examiner or captain will forward the compromise settlement agreement, authorized by both parties, to the board for approval.

(i) If the board approves the compromise, a copy of the signed settlement agreement will be sent to the licensee or permit holder, and will become part of the licensing history.

(ii) If the board does not approve the compromise, the licensee or permit holder will be notified of the decision. The licensee or permit holder will be given the option to renegotiate with the hearings examiner or captain, of accepting the originally recommended penalty, or of requesting an administrative hearing on the charges.

(d) If the licensee or permit holder and the hearing examiner or captain cannot reach agreement on a settlement proposal, the licensee may accept the originally recommended penalty, or the hearing examiner or captain will forward a request for an administrative hearing to the board's hearings coordinator.

WSR 09-13-038
PERMANENT RULES
TRANSPORTATION COMMISSION

[Filed June 10, 2009, 1:14 p.m., effective July 11, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule establishes toll rates for the Tacoma Narrows Bridge. Revising the rule to extend the toll rates past June 30, 2009.

Citation of Existing Rules Affected by this Order: Amending WAC 468-270-070.

Statutory Authority for Adoption: RCW 47.56.240.

Adopted under notice filed as WSR 09-10-067 on May 5, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 1, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 10, 2009.

Reema Griffith
Executive Director

AMENDATORY SECTION (Amending WSR 08-12-054, filed 6/2/08, effective 7/3/08)

WAC 468-270-070 What will the toll rates be for the Tacoma Narrows Bridge?

Tacoma Narrows Bridge
Proposed Toll Rates[1] for All Vehicles((1)) [2]

		((~~7/1/2008 - 6/30/2009~~[2]))	
Vehicle Type	Axles	Cash	Electronic[3]
Passenger vehicle/Motorcycle	2	$4.00	$2.75
Passenger vehicle with small trailer	3	$6.00	$4.15
Tractor trailer rig/Passenger vehicle with trailer	4	$8.00	$5.50
Tractor trailer with big trailer	5	$10.00	$6.90
Tractor trailer with bigger trailer (6 or more axles)	6	$12.00	$8.25

Note:

[1]The toll rates are in effect until changed by the commission.

[2]The base toll rate per axle. It is only used to calculate multi-axle rates, which are calculated as a multiplier of the base toll rate ($2.00 for cash and $1.375 for electronic toll rates).

(([2]~~The toll rates are in effect through June 30, 2009, or until changed by the commission.~~))

[3]The rate for the electronic tolls has been rounded up to the nearest five cents where appropriate.

WSR 09-13-053
PERMANENT RULES
WESTERN WASHINGTON UNIVERSITY

[Filed June 12, 2009, 9:34 a.m., effective July 13, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: As part of the university's rule review process, university residences drafted amendments to its WAC rules. The amendments were made to better reflect Western's university vision and mission statement and include general housekeeping updates.

Citation of Existing Rules Affected by this Order: Amending WAC 516-56-001.

Statutory Authority for Adoption: RCW 28B.35.120(12).

Adopted under notice filed as WSR 09-07-034 on March 10, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 12, 2009.

Suzanne M. Baker
Rules Coordinator

AMENDATORY SECTION (Amending WSR 98-14-051, filed 6/26/98, effective 7/27/98)

WAC 516-56-001 Housing and dining—General. ((~~The objectives of the housing and dining areas maintained by~~)) Students in university residences enhance their Western ((~~Washington University are to provide comfortable, democratic, living conditions conducive to successful academic achievement and to participation in the activities of~~)) experience in diverse and inclusive communities that foster active learning, leadership, social responsibility, civic engagement, and effective citizenship, supported by a high quality, attractive, and sustainable campus ((~~life~~)) environment.

Western is committed to engaged excellence in fulfilling its tripartite mission of teaching, scholarship, and community service in a student-centered environment, with a liberal arts foundation and opportunities to develop professional skills. Western provides students with a personalized teaching and learning environment of the highest quality.

((~~All~~)) Rules, regulations, policies, procedures and general information are found in the *((~~WWU Office of University Residences~~)) On-Campus Housing Agreement, Guide to University Residences, ((~~Room and Board Agreement, Birnam Wood Apartment Agreement,~~))* and((~~/or~~)) the *Residential Community Handbook*, subject to periodic review and revisions. ((~~Please contact the Office of~~)) Up-to-date information is available on Western's web site at www.housing.wwu.edu, via e-mail at infodesk@wwu.edu, or by writing to University Residences, Edens Hall 101, ((~~WWU~~)) Western Washington University, Bellingham, Washington, ((~~for the most up-to-date information~~)) 98225-9195.

WSR 09-13-057
PERMANENT RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed June 12, 2009, 2:06 p.m., effective July 13, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Section 12, chapter 3, Laws of 2009, amended RCW 50.60.100 to remove language restricting individuals to twenty-six weeks of shared work benefits during any twelve month period. The amendment to WAC 192-250-035 incorporates this change in statute. The amendment to WAC 192-250-045 is to correct the term "benefit ratio" to "tax rate."

Citation of Existing Rules Affected by this Order: Amending WAC 192-250-035 and 192-250-045.

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, and 50.60.901.

Adopted under notice filed as WSR 09-08-068 on March 27, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 3, 2009.

Karen T. Lee
Commissioner

AMENDATORY SECTION (Amending WSR 06-22-004, filed 10/19/06, effective 11/19/06)

WAC 192-250-035 Information for employees participating in an approved shared work plan. (1) **What are the requirements for participating in my employer's plan?** You must have at least four hundred sixty hours of work with this employer in the calendar quarter before the quarter in which your employer's application is submitted.

(2) **When do I apply for benefits?** Your employer representative will tell you if you need to apply for benefits and how to do so. If you have a current valid claim, you do not need to apply again.

(3) **How do I file my weekly claim for benefits?** See WAC 192-140-005 for instructions on filing weekly claims. You must also report the number of hours you were paid for holidays, vacations, or sick leave. You must report hours and gross earnings for part-time and second jobs, plus your hours and net earnings from any self-employment. You can file weekly claims by telephone or over the internet.

(4) **What happens if the total number of hours worked is not a whole number?** If the total number of hours you worked in a week includes a fraction of an hour, the department will round the total down to the next whole number. This rounded number will be compared to your usual hours of work to calculate your shared work benefit payment for the week. For example: You work 28.5 hours of a normal 40 hour week. The 28.5 hours is rounded down to 28 hours and then divided by 40, meaning you worked 70 percent of the available hours. Your shared work payment would be 30 percent of your regular weekly benefit amount.

(5) **What happens if I don't work all scheduled hours for my shared work employer?**

(a) You are not eligible for shared work benefits for any week that you do not work all hours you have been scheduled by your shared work employer.

(b) You must be available for additional hours of work, up to full time, with the shared work employer. If your employer gives you at least twenty-four hours' notice that additional work is available and you do not work those additional hours, you are not eligible for shared work benefits for that week.

(c) When you are not eligible for shared work benefits in any week claimed, your claim will be processed as a regular unemployment claim.

(6) **Do I have to look for work while participating in the shared work program?** No. You are not required to look for work while participating in the shared work program.

(7) **Is there a minimum or maximum number of hours I can work in a week and still receive shared work benefits?** You must have twenty to thirty-six hours of paid time during a week to receive shared work benefits. In any week you are paid for fewer than twenty hours or more than thirty-six hours, your claim will be processed as a regular unemployment claim.

(8) **How long can I receive shared work benefits?** You can receive ((~~up to twenty-six weeks of~~)) shared work payments up to the maximum benefit entitlement established under Title 50 RCW, plus state or federal benefit extensions under Chapter 50.22 RCW ((~~during your benefit year, depending on the maximum amount of benefits available on your claim. The twenty-six weeks do not have to be claimed consecutively. Your waiting week counts as one of the twenty-six weeks of shared work payments~~)).

AMENDATORY SECTION (Amending WSR 06-22-004, filed 10/19/06, effective 11/19/06)

WAC 192-250-045 Who is not eligible for participation in the shared work program? (1) The following employees are not eligible for participation in the shared work program:

(a) Employees paid on any basis other than hourly wage. This includes, but is not limited to, employees paid on a piece rate, mileage rate, job rate, salary, or commission basis. The commissioner may waive this provision for employees paid on a piece rate basis if an hourly rate of pay can be established.

(b) Officers of the corporation that is applying for participation.

(2) The following businesses are not eligible for participation in the shared work program:

(a) Businesses with a ((~~benefit ratio~~)) tax rate of more than 5.4 percent.

(b) Nonqualified employers, meaning employers who have reported no payroll for four consecutive quarters.

WSR 09-13-058

PERMANENT RULES

BOARD OF PILOTAGE COMMISSIONERS

[Filed June 15, 2009, 10:22 a.m., effective August 1, 2009]

Effective Date of Rule: August 1, 2009.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: All requirements necessary to amend the existing Grays Harbor pilotage district tariff as set forth in chapter 53.08 RCW have been met.

Purpose: To establish an annual tariff for pilotage services in the Grays Harbor pilotage district.

Citation of Existing Rules Affected by this Order: Amending WAC 363-116-185.

Statutory Authority for Adoption: RCW 88.16.035.

Adopted under notice filed as WSR 09-10-004 on April 22, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 1, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: June 11, 2009.

Peggy Larson
Administrator

AMENDATORY SECTION (Amending WSR 08-14-073, filed 6/26/08, effective 8/1/08)

WAC 363-116-185 Pilotage rates for the Grays Harbor pilotage district. Effective 0001 hours August 1, ((~~2008~~)) 2009, through 2400 hours July 31, ((~~2009~~)) 2010.

CLASSIFICATION	RATE
Charges for piloting of vessels in the inland waters and tributaries of Grays Harbor shall consist of the following:	
Draft and Tonnage Charges:	
Each vessel shall be charged according to its draft and tonnage for each vessel movement inbound to the Grays Harbor pilotage district, and for each movement outbound from the district.	
Draft	$((~~97.20~~)) 100.12 per meter or $((~~29.62~~)) 30.51 per foot
Tonnage	$((~~0.279~~)) 0.287 per net registered ton
Minimum Net Registered Tonnage	$((~~975.00~~)) 1,004.00
Extra Vessel (in case of tow)	$((~~546.00~~)) 562.00
Provided that, due to unique circumstances in the Grays Harbor pilotage district, vessels that call, and load or discharge cargo, at Port of Grays Harbor Terminal No. 2 shall be charged $((~~5,400.00~~)) 5,562.00 per movement for each vessel movement inbound to the district for vessels that go directly to Terminal No. 2, or that go to anchor and then go directly to Terminal No. 2, or because Terminal No. 2 is not available upon arrival that go to layberth at Terminal No. 4 (without loading or discharging cargo) and then go directly to Terminal No. 2, and for each vessel movement outbound from the district from Terminal No. 2, and that this charge shall be in lieu of only the draft and tonnage charges listed above.	
Boarding Charge:	
Per each boarding/deboarding from a boat or helicopter	$1,030.00
Harbor Shifts:	
For each shift from dock to dock, dock to anchorage, anchorage to dock, or anchorage to anchorage	$((~~679.00~~)) 699.00
Delays per hour	$((~~159.00~~)) 164.00
Cancellation charge (pilot only)	$((~~266.00~~)) 274.00
Cancellation charge (boat or helicopter only)	$((~~798.00~~)) 822.00
Two Pilots Required:	
When two pilots are employed for a single vessel transit, the second pilot charge shall include the harbor shift charge of $699.00 and in addition, when a bridge is transited the bridge transit charge of $301.00 shall apply.	
Pension Charge:	
Charge per pilotage assignment, including cancellations	$((~~197.00~~)) 226.00
Travel Allowance:	
Transportation charge per assignment	$100.00
Pilot when traveling to an outlying port to join a vessel or returning through an outlying port from a vessel which has been piloted to sea shall be paid $931.00 for each day or fraction thereof, and the travel expense incurred.	
Bridge Transit:	
Charge for each bridge transited	$((~~292.00~~)) 301.00
Additional surcharge for each bridge transited for vessels in excess of 27.5 meters in beam	$((~~809.00~~)) 833.00
Miscellaneous:	
The balance of amounts due for pilotage rates not paid within 30 days of invoice will be assessed at 1 1/2% per month late charge.	

WSR 09-13-066
PERMANENT RULES
CRIMINAL JUSTICE TRAINING COMMISSION
[Filed June 16, 2009, 8:21 a.m., effective July 17, 2009]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The changes to these rules update RCW references; update the name of the commission to reflect our identity specifically with online searches; consolidate rules; repeal rules that were incorporated into the updated rules; update the cost of copies, cost for electronic records, and payment information; use plain language; and make clear who to contact for public records and the process.

Citation of Existing Rules Affected by this Order: Repealing WAC 139-02-020, 139-02-030, 139-02-060, 139-02-080, 139-02-100 and 139-02-110; and amending WAC 139-02-010, 139-02-040, 139-02-050, 139-02-070, and 139-02-090.

Statutory Authority for Adoption: RCW 43.56.040 and 43.101.080.

Adopted under notice filed as WSR 09-07-083 on March 17, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 6, Repealed 5.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 6, Repealed 5.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 10, 2009.

Sonja Hirsch
Rules Coordinator

AMENDATORY SECTION (Amending WSR 00-17-017, filed 8/4/00, effective 9/4/00)

WAC 139-02-010 Authority and purpose. ((~~The purpose of this chapter shall be to ensure compliance by the criminal justice training commission with the provisions of the Public Records Disclosure Act, RCW 42.17.250 through 42.17.340.~~)) (1) RCW 42.56.070(1) requires each agency to make available for inspection and copying nonexempt "public records" in accordance with published rules. The act defines "public record" to include any "writing containing information relating to the conduct of government or the performance of any governmental or proprietary function prepared, owned, used, or retained" by the agency. RCW 42.56.070(2) requires each agency to set forth "for informational purposes" every law, in addition to the Public Records Act (the act), that exempts or prohibits the disclosure of public records held by that agency.

(2) The purpose of these rules is to establish the procedures the Washington state criminal justice training commission shall follow in order to provide full access to public records. These rules provide information to persons wishing to request access to public records of the Washington state criminal justice training commission and establish processes for both requestors and Washington state criminal justice training commission staff that are designed to best assist members of the public in obtaining such access.

(3) The purpose of the act is to provide the public full access to information concerning the conduct of government, mindful of individuals' privacy rights and the desirability of the efficient administration of government. In carrying out its responsibilities under the act, the Washington state criminal justice training commission shall be guided by the provisions of the act describing its purposes and interpretation.

AMENDATORY SECTION (Amending WSR 05-01-109, filed 12/15/04, effective 1/15/05)

WAC 139-02-040 Public ((~~disclosure~~)) records officer. ((~~The commission shall designate a public disclosure officer who shall be responsible for implementing the commission's rules regarding disclosure of public records, coordination of staff in this regard, and generally insuring compliance by the staff with public records disclosure requirements.~~)) (1) The Washington state criminal justice training commission is the state training academy for law enforcement and corrections professionals. The Washington state criminal justice training commission's campus is located in Burien, WA at 19010 1st Avenue South. The Washington state criminal justice training commission has a fiscal office in Lacey, WA located at 3060 Willamette Drive N.E.

(2) Any person wishing to request access to public records of the Washington state criminal justice training commission, or seeking assistance in making such a request, should contact the public records officer of the Washington state criminal justice training commission:

Public Records Officer
Washington State Criminal Justice Training Commission
MS: TB-35
19010 1st Avenue South
Burien, WA 98148
Phone: 206-835-7300
Fax: 206-835-7924
E-mail: publicrecords@cjtc.state.wa.us

Information is also available at the Washington state criminal justice training commission's web site at www.cjtc.state.wa.us.

(3) The public records officer will oversee compliance with the act, but another Washington state criminal justice training commission staff member may process the request. Therefore, these rules will refer to the public records officer or designee. The public records officer or designee and the Washington state criminal justice training commission will provide the fullest assistance to requestors; create and maintain for use by the public and Washington state criminal justice training commission officials an index to public records

of the Washington state criminal justice training commission; ensure that public records are protected from damage or disorganization; and prevent fulfilling public records requests from causing excessive interference with essential functions of the Washington state criminal justice training commission.

AMENDATORY SECTION (Amending WSR 00-17-017, filed 8/4/00, effective 9/4/00)

WAC 139-02-050 ((~~Request for~~)) Availability of public records. ((~~(1) Unless waived by a public disclosure officer, all requests for the disclosure of a public record must be in writing identifying the record sought with reasonable certainty. The written request may include:~~

~~(a) The name of the person requesting the record;~~

~~(b) The calendar date on which the request is made; and~~

~~(c) The nature of the request.~~

~~(2) An in-person request for disclosure shall be made during customary business hours.~~

~~(3) If the public record contains material exempt from disclosure pursuant to law, the commission must provide the person requesting disclosure with a written explanation for the nondisclosure, pursuant to WAC 137-08-130.~~

~~(4) When a person's identity is relevant to an exemption, that person may be required to provide personal identification.~~

~~(5) Nothing in this section or elsewhere in this chapter shall be construed to require the commission to compile statistics or other information from material contained in public records, where doing so would unduly interfere with other essential functions of the commission and is not required for litigation by rules of pretrial discovery.~~)) (1) **Hours for inspection of records.** Public records are available for inspection and copying during normal business hours of the Washington state criminal justice training commission; 8:00 a.m. to noon, and 1:00 p.m. to 4:00 p.m., Monday through Friday, excluding legal holidays. Records must be inspected at the offices of the Washington state criminal justice training commission.

(2) **Records index.** An index of public records is available for use by members of the public. The index includes a list of current manuals of the Washington state criminal justice training commission, a current list of laws, other than those listed in chapter 42.56 RCW, that exempts or prohibits disclosure of specific information or records, and current Washington Administrative Code agency rules. The index may be accessed on-line at www.cjtc.state.wa.us or at the Washington state criminal justice training commission in Burien.

(3) **Organization of records.** The Washington state criminal justice training commission maintains its records in a reasonably organized manner and takes reasonable actions to protect records from damage and disorganization. A requestor shall not take Washington state criminal justice training commission records from Washington state criminal justice training commission offices without the permission of the public records officer or designee. Records may be available on the Washington state criminal justice training commission web site at www.cjtc.state.wa.us. Requestors are encouraged to view the documents available on the web site prior to submitting a records request.

(4) **Making a request for public records.**

(a) Any person wishing to inspect or obtain copies of public records of the Washington state criminal justice training commission shall make the request in writing using the Washington state criminal justice training commission request form, or by letter, fax, or e-mail addressed to the public records officer. Each request should include the following information:

- Name of requestor;
- Address of requestor;
- Other contact information, including telephone number and/or an e-mail address; and
- Identification of the public records adequate for the public records officer or designee to locate the records.

(b) If requestors wish to inspect rather than obtain copies of records, they must indicate this preference in their requests. Pursuant to WAC 139-02-070, standard photocopies are provided at fifteen cents per page, plus postage.

AMENDATORY SECTION (Amending WSR 00-17-017, filed 8/4/00, effective 9/4/00)

WAC 139-02-070 ((~~Fees—Inspection and copying.~~)) Costs for providing copies of public records. ((~~(1) No fee shall be charged for the inspection of public records.~~

~~(2) The commission shall collect a fee of twenty cents per page plus postage as reimbursement for the cost of providing copies of public records.~~

~~(3) Nothing contained in this section shall preclude the commission from agreeing to exchange or provide copies of manuals or other public records with other state or federal agencies, whenever doing so is in the best interest of the commission.~~

~~(4) The director of the commission or his or her designee is authorized to waive any of the foregoing copying costs.~~)) (1) Costs for paper copies. There is no fee charged for inspecting public records. A requestor may obtain standard black and white photocopies for fifteen cents per page. Before beginning to make copies, the public records officer or designee may estimate costs of copying the records, and may require a deposit of up to ten percent of all the records selected by the requestor. The public records officer or designee may also require the payment of the remainder of the copying costs before providing all the records, or the payment of the costs of copying an installment before providing that installment. The Washington state criminal justice training commission will not charge sales tax when it makes copies of public records.

(2) Costs for electronic records. The cost of electronic copies of records shall be the actual cost of the CD, DVD, audio or video tape, or disc.

(3) Costs of mailing. The Washington state criminal justice training commission may also charge actual costs of mailing, including the cost of the shipping container.

(4) Payment. Payment may be made by check or money order only, payable to the Washington state criminal justice training commission.

AMENDATORY SECTION (Amending WSR 00-17-017, filed 8/4/00, effective 9/4/00)

WAC 139-02-090 ((~~Disclosure procedure.~~)) Processing requests for public records. (((~~1) The public disclosure officer shall review file materials prior to disclosure.~~

~~(2) If the file does not contain materials exempt from disclosure, the public disclosure officer shall ensure full disclosure.~~

~~(3) If the file does contain materials exempt from disclosure, the public disclosure officer shall deny disclosure of those exempt portions of the file, and shall, at the time of the denial, in writing, clearly specify the reasons for the denial of disclosure, including a statement of the specific exemptions or reasons authorizing the withholding of the record and a brief explanation of how the exemption or reason applies. The remaining, nonexempt materials shall be fully disclosed.~~)) (1) **Providing fullest assistance.** The Washington state criminal justice training commission is charged by statute with adopting rules which provide for how it shall "provide full access to public records," "protect records from damage or disorganization," "prevent excessive interference with other essential functions of the agency," provide "fullest assistance" to requestors, and provide the "most timely possible action" on public records requests. The public records officer or designee shall process requests in the order they are received and allowing for the most requests to be processed in the most efficient manner.

(2) **Acknowledging receipt of request.** Within five business days of receipt of the request, the public records officer or designee will do one or more of the following:

(a) Make the records available for inspection;

(b) Provide the requested records (or provide a bill for the records if applicable) to the requestor;

(c) Provide a reasonable estimate of when records will be available; or

(d) Deny the request and provide a statutory explanation as to the reason for the denial.

(3) **Consequences of failure to respond.** If the Washington state criminal justice training commission does not respond in writing within five business days of receipt of the request for disclosure, the requestor should consider contacting the public records officer to determine the reason for the failure to respond.

(4) **Protecting rights of others.** In the event that the requested records contain information that may affect rights of others and may be exempt from disclosure, the public records officer or designee may, prior to providing the records, give notice to such others whose rights may be affected by the disclosure. This notice is given so affected persons may seek an order from a court to prevent or limit the disclosure. The notice to the affected persons may include a copy of the request.

(5) **Records exempt from disclosure.** Some records are exempt from disclosure, in whole or in part. If the Washington state criminal justice training commission believes that a record is exempt from disclosure and should be withheld, the public records officer or designee will state the specific exemption and provide a brief explanation of why the record or a portion of the record is being withheld. If only a portion of a record is exempt from disclosure, but the remainder is not exempt, the public records officer or designee will redact the exempt portions, provide the nonexempt portions, and indicate to the requestor why portions of the record are being redacted.

(6) **Inspection of records.**

(a) Consistent with other demands, the Washington state criminal justice training commission will provide space to inspect public records. No member of the public may remove a document from the viewing area or disassemble or alter any document without approval from the public records officer or designee. The requestor will indicate which documents he or she wishes the agency to copy.

(b) The requestor must claim or review the assembled records within thirty days of the Washington state criminal justice training commission's notification to him or her that the records are available for inspection or copying. The Washington state criminal justice training commission will notify the requestor in writing of this requirement and inform the requestor that he or she is to contact the agency to make arrangements to claim or review the records. If the requestor or a representative of the requestor fails to claim or review the records within the thirty-day period or make other arrangements, the Washington state criminal justice training commission may close the request and refile the assembled records. Other public records requests can be processed ahead of a subsequent request by the same person for the same or almost identical records, which may be processed as a new request.

(7) **Providing copies of records.** After inspection is complete or in lieu of inspection, the public records officer or designee will make the requested copies or arrange for copying and provide them to the requestor.

(8) **Providing records in installments.** When the request is for a large number of records, the public records officer or designee may provide access for inspection and copying in installments, if he or she reasonably determines that it would be more practical. If, within thirty days, the requestor fails to inspect one or more of the installments, the public records officer or designee may stop searching for the remaining records and close the request.

(9) **Completion of inspection.** When the inspection of the requested records is complete and all requested copies are provided, the public records officer or designee will indicate that the Washington state criminal justice training commission has completed the request and provided all available (nonexempt) records.

(10) **Closing withdrawn or abandoned request.** When the requestor either withdraws the request or fails to fulfill his or her obligations to inspect the records or pay the deposit or final payment for the requested copies, the public records officer will close the request and indicate to the requestor that the Washington state criminal justice training commission has closed the request and refile the assembled records.

(11) **Later discovered documents.** If, after the Washington state criminal justice training commission has informed the requestor that it has provided all available records, the Washington state criminal justice training commission becomes aware of additional responsive documents existing at the time of the request, it will promptly inform the

requestor of the additional documents and provide them on an expedited basis.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 139-02-020	Definitions.
WAC 139-02-030	Public records available.
WAC 139-02-060	Disclosure to client's representative.
WAC 139-02-080	Protection of public records.
WAC 139-02-100	Qualifications on nondisclosure.
WAC 139-02-110	Records index.

WSR 09-13-102
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed June 17, 2009, 9:13 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: This may become effective earlier than thirty-one days after filing per RCW 34.05.380 (3)(a) because RCW 70.02.010(15) directs us to adjust the amount biennially.

Purpose: WAC 246-08-400 Allowable fees for searching and duplicating medical records. The department is making the biennial adjustment to the maximum amounts health care providers can charge for searching and duplicating medical records. RCW 70.02.010(15) requires the department to adjust the amounts every biennium based on the change in the consumer price index (CPI) for the Seattle-Tacoma area. The amounts will increase by 6.3%.

Citation of Existing Rules Affected by this Order: Amending WAC 246-08-400.

Statutory Authority for Adoption: RCW 70.02.010(15) and 43.70.040.

Adopted under notice filed as WSR 09-09-036 on April 7, 2009.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: June 17, 2009.

Mary C. Selecky
Secretary

AMENDATORY SECTION (Amending WSR 07-12-029, filed 5/30/07, effective 7/1/07)

WAC 246-08-400 How much can a medical provider charge for searching and duplicating medical records? RCW 70.02.010(15) allows medical providers to charge fees for searching and duplicating medical records. The fees a provider may charge cannot exceed the fees listed below:

(1) Copying charge per page:

(a) No more than ((~~ninety-six~~)) one dollar and two cents per page for the first thirty pages;

(b) No more than ((~~seventy-three~~)) seventy-eight cents per page for all other pages.

(2) Additional charges:

(a) The provider can charge a ((~~twenty-two~~)) twenty-three dollar clerical fee for searching and handling records;

(b) If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit.

(3) This section is effective July 1, ((~~2007~~)) 2009, through June 30, ((~~2009~~)) 2011.

(4) HIPAA covered entities: See HIPAA regulation Section 164.524 (c)(4) to determine applicability of this rule.