WSR 11-02-026
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)
[Filed December 29, 2010, 1:26 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating a number [of] optional medical services from program benefits packages for clients twenty-one years of age and older. These medical services include vision, hearing, and dental care. Sections in chapter 388-501 WAC are being amended to reflect and support these program cuts.

Citation of Existing Rules Affected by this Order: Amending WAC 388-501-0050, 388-501-0060, 388-501-0065, 388-501-0070, and 388-502-0160.

Statutory Authority for Adoption: RCW 74.08.090.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

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

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-07-116, filed 3/22/10, effective 4/22/10)

WAC 388-501-0050 Healthcare general coverage. (1) WAC 388-501-0050 through 388-501-0065 describe the healthcare services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 388-538-050). For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. WAC 388-501-0070 describes noncovered services. The following definitions apply to this chapter:

(((~~(1)~~))) (a) **"Benefits package"** means the set of healthcare service categories included in a client's eligibility program. See the table in WAC 388-501-0060.

(b) **"Healthcare service categories"** means the groupings of healthcare services listed in the table in WAC 388-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

(c) **"Covered service"** means a specific healthcare service within a service category that the department will pay for when all healthcare program requirements have been met.

(d) **"Noncovered service"** means a specific healthcare service within a service category that the department will not pay for. Noncovered services are identified in WAC 388-501-0070 and in specific health-care program rules.

(2) Healthcare service categories listed in WAC 388-501-0060 do not represent a contract for healthcare services.

(((~~(2)~~))) (3) For the provider to receive payment, the client must be eligible for the covered healthcare service on the date the healthcare service is performed or provided.

(((~~(3)~~))) (4) Under the department's fee-for-service programs, providers must be enrolled with the department and meet the requirements of chapter 388-502 WAC to be paid for furnishing healthcare services to clients.

(((~~(4)~~))) (5) The department pays only for the healthcare services that are:

(a) ((~~Within the scope of~~)) Included in the client's ((~~medical program~~)) healthcare benefits package as described in WAC 388-501-0060;

(b) Covered - see subsection (((~~(9)~~))) (10) of this section;

(c) Ordered or prescribed by a healthcare provider who meets the requirements of chapter 388-502 WAC;

(d) Medically necessary as defined in WAC 388-500-0005;

(e) Submitted for authorization, when required, in accordance with WAC 388-501-0163;

(f) Approved, when required, in accordance with WAC 388-501-0165;

(g) Furnished by a provider according to chapter 388-502 WAC; and

(h) Billed in accordance with department program rules and the department's current published billing instructions and numbered memoranda.

(((~~(5)~~))) (6) The department does not pay for any healthcare service requiring prior authorization from the department, if prior authorization was not obtained before the healthcare service was provided; unless:

(a) The client is determined to be retroactively eligible for medical assistance; and

(b) The request meets the requirements of subsection (4) of this section.

(((~~(6)~~))) (7) The department does not reimburse clients for healthcare services purchased out-of-pocket.

(((~~(7)~~))) (8) The department does not pay for the replacement of department-purchased equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, or misuse unless:

(a) Extenuating circumstances exist that result in a loss or destruction of department-purchased equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or

(b) Otherwise allowed under chapter 388-500 WAC.

(((~~(8)~~))) (9) The department's refusal to pay for replacement of equipment, device, or supplies will not extend beyond the limitations stated in specific department program rules.

(((~~(9)~~))) (10) **Covered healthcare services**

(a) Covered healthcare services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the healthcare service for medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the healthcare service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered healthcare services. Limitation extensions are authorized according to WAC 388-501-0169.

(((~~(10)~~))) (11) **Noncovered healthcare services**

(a) The department does not pay for any healthcare service((~~:~~

~~(i) That federal or state laws or regulations prohibit the department from covering; or~~

~~(ii)~~))) listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered healthcare service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When a noncovered healthcare service is recommended during the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam and then ordered by a provider, the department evaluates the healthcare service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

AMENDATORY SECTION (Amending WSR 06-24-036, filed 11/30/06, effective 1/1/07)

WAC 388-501-0060 Healthcare coverage—((~~Scope of covered categories of service~~)) Program benefits packages—Scope of service categories. (1) ((~~This rule provides a list (see subsection (5)) of medical, dental, mental health, and substance abuse categories of service covered by the department under categorically needy (CN) medicaid, medically needy (MN) medicaid, Alien Emergency Medical (AEM), and medical care services (MCS) programs. MCS means the limited scope of care financed by state funds and provided to general assistance and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program clients.~~

~~(2) Not all categories of service listed in this section are covered under every medical program, nor do they represent a contract for services. Services are subject to the exclusions, limitations, and eligibility requirements contained in department rules.~~

~~(3) Services covered under each listed category:~~

~~(a) Are determined by the department after considering available evidence relevant to the service or equipment to:~~

~~(i) Determine efficacy, effectiveness, and safety;~~

~~(ii) Determine impact on health outcomes;~~

~~(iii) Identify indications for use;~~

~~(iv) Compare alternative technologies; and~~

~~(v) Identify sources of credible evidence that use and report evidence based information.~~

~~(b) May require prior authorization (see WAC 388-501-0165), or expedited authorization when allowed by the department.~~

~~(c) Are paid for by the department and subject to review both before and after payment is made. The department or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.~~

~~(4) The department does not pay for covered services, equipment, or supplies that:~~

~~(a) Require prior authorization from the department, if prior authorization was not obtained before the service was provided;~~

~~(b) Are provided by providers who are not contracted with the department as required under chapter 388-502 WAC;~~

~~(c) Are included in a department waiver program identified in chapter 388-515 WAC; or~~

~~(d) Are covered by a third-party payer (see WAC 388-501-0200), including medicare, if the third-party payer has not made a determination on the claim or has not been billed by the provider.~~

~~(5) **Scope of covered service categories.** The following table lists the department's covered categories of healthcare services.~~

~~• Under the four program columns (CN, MN, MCS, and AEM), the letter "C" means a service category is covered for that program, subject to any limitations listed in the specific medical assistance program WAC and department issuances.~~

~~• The letter "N" means a service category is not covered under that program.~~

~~• The letter "E" means the service category is available on ly if it is necessary to treat the client's emergency medical~~

~~condition and may require prior authorization from the department.~~

~~• Refer to WAC 388-501-0065 for a description of each service category and for the specific program WAC containing the limitations and exclusions to services.~~

~~Service Categories~~	~~CN*~~	~~MN~~	~~MCS~~	~~AEM~~
~~(a) Adult day health~~	~~C~~	~~C~~	~~N~~	~~E~~
~~(b) Ambulance (ground and air)~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(c) Blood processing/administration~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(d) Dental services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(e) Detoxification~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(f) Diagnostic services (lab & x-ray)~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(g) Family planning services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(h) Healthcare professional services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(i) Hearing care (audiology/hearing exams/aids)~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(j) Home health services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(k) Hospice services~~	~~C~~	~~C~~	~~N~~	~~E~~
~~(l) Hospital services -inpatient/outpatient~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(m) Intermediate care facility/services for mentally retarded~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(n) Maternity care and delivery services~~	~~C~~	~~C~~	~~N~~	~~E~~
~~(o) Medical equipment, durable (DME)~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(p) Medical equipment, nondurable (MSE)~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(q) Medical nutrition services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(r) Mental health services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(s) Nursing facility services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(t) Organ transplants~~	~~C~~	~~C~~	~~C~~	~~N~~
~~(u) Out-of-state services~~	~~C~~	~~C~~	~~N~~	~~E~~
~~(v) Oxygen/respiratory services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(w) Personal care services~~	~~C~~	~~C~~	~~N~~	~~N~~
~~(x) Prescription drugs~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(y) Private duty nursing~~	~~C~~	~~C~~	~~N~~	~~E~~
~~(z) Prosthetic/orthotic devices~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(aa) School medical services~~	~~C~~	~~C~~	~~N~~	~~N~~
~~(bb) Substance abuse services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(cc) Therapy -occupational/physical/speech~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(dd) Vision care (exams/lenses)~~	~~C~~	~~C~~	~~C~~	~~E~~

~~*Clients enrolled in the State Children's Health Insurance Program and the Children's Health Program receive CN scope of medical care~~)) This rule provides a table that lists:

(a) The categorically needy (CN) medicaid, medically needy (MN) medicaid, and medical care services (MCS) programs; and

(b) The benefits packages showing what service categories are included for each program.

(2) Within a service category included in a benefits package, some services may be covered and others noncovered.

(3) Services covered within each service category included in a benefits package:

(a) Are determined, in accordance with WAC 388-501-0050 and 388-501-0055 when applicable.

(b) May be subject to limitations, restrictions, and eligibility requirements contained in department rules.

(c) May require prior authorization (see WAC 388-501-0165), or expedited authorization when allowed by the department.

(d) Are paid for by the department and subject to review both before and after payment is made. The department or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The department does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the department, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the department as required under chapter 388-502 WAC;

(c) Are included in a department waiver program identified in chapter 388-515 WAC; or

(d) Are covered by a third-party payer (see WAC 388-501-0200), including medicare, if the third-party payer has not made a determination on the claim or has not been billed by the provider.

(5) Other programs:

(a) Early and periodic screening, diagnosis, and treatment (EPSDT) services are not addressed in the table. For EPSDT services, see chapter 388-534 WAC and WAC 388-501-0050(10).

(b) Alien emergency medical (AEM) services are not addressed in the table. For AEM services, see chapter 388-438 WAC.

(6) **Scope of service categories.** The following table lists the department's categories of healthcare services.

(a) Under the CN and MN headings there are two columns - one addressing clients twenty years of age and younger and the other addresses clients twenty-one years of age and older.

(b) Under the MCS heading, "**DL**" refers to the disability lifeline medical program.

(c) The letter "**I**" means a service category is included for that program. Services within each service category are subject to limitations and restrictions listed in the specific medical assistance program WAC and department issuances.

(d) The letter "**E**" means a service category is excluded under that program.

(e) Refer to WAC 388-501-0065 for a description of each service category and for the specific program WAC containing the limitations and restrictions to services.

Service Categories	CN[1]		MN		MCS
	20-	21+	20-	21+	DL
Adult day health	I	I	I[2]	E	E

Service Categories	CN[1]		MN		MCS
	20-	21+	20-	21+	DL
Ambulance (ground and air)	I	I	I	I	I
Blood processing / administration	I	I	I	I	I
Dental services	I	E	I	E	E
Detoxification	I	I	I	I	I
Diagnostic services (lab & x-ray)	I	I	I	I	I
Healthcare professional services	I	I	I	I	I
Hearing evaluations	I	I	I	I	I
Hearing aids	I	E	I	E	E
Home health services	I	I	I	I	I
Hospice services	I	I	I	I	I
Hospital services - inpatient/outpatient	I	I	I	I	I
Intermediate care facility/services for mentally retarded	I	I	I	I	I
Maternity care and delivery services	I	I	I	I	E
Medical equipment, durable (DME)	I	I	I	I	I
Medical equipment, nondurable (MSE)	I	I	I	I	I
Medical nutrition services	I	I	I	I	I
Mental health services:					
• inpatient care	I	I	I	I	I
• outpatient community mental health services	I	I	I	I	I[3]
• psychiatrist visits	I	I	I	I	I[4]
• medication management	I	I	I	I	I
Nursing facility services	I	I	I	I	I
Organ transplants	I	I	I	I	I
Out-of-state services	I	I	I	I	E
Oxygen/respiratory services	I	I	I	I	I
Personal care services	I	I	E	E	E
Prescription drugs	I	I	I	I	I
Private duty nursing	I	I	I	I	E
Prosthetic/orthotic devices	I	I	I	I	I
Psychological evaluation[5]	I	I	I	I	E
Reproductive health services (includes family planning and TAKE CHARGE	I	I	I	I	I
Substance abuse services	I	I	I	I	I
Therapy - occupational, physical, and speech	I	I	I	I	I
Vision care - exams, refractions, and fittings	I	I	I	I	I
Vision - frames and lenses	I	E	I	E	E

[1] Clients enrolled in the children's health insurance program and the apple health for kids program receive CN-scope of medical care.

[2] Restricted to 18-20 year olds.

[3] Restricted to DL clients enrolled in managed care.

[4] DL clients can receive one psychiatric diagnostic evaluation per year and eleven monthly visits per year for medication management.

[5] Only two allowed per lifetime.

. **Reviser's note:** RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

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 06-24-036, filed 11/30/06, effective 1/1/07)

WAC 388-501-0065 Healthcare coverage—Description of ((~~covered~~)) categories of service. This rule provides a brief description of the medical, dental, mental health, and substance abuse service categories listed in the table in WAC 388-501-0060. The description of services under each category is not intended to be all inclusive.

(1) For categorically needy (CN), medically needy (MN), and medical care services (MCS), refer to the WAC citations listed in the following descriptions for specific details regarding each service category. ((~~For Alien Emergency Medical (AEM) services, refer to WAC 388-438-0110.~~))

(2) The following service categories are subject to the exclusions, limitations, restrictions, and eligibility requirements contained in department rules:

(a) **Adult day health**—((~~Skilled nursing services, counseling, therapy (physical, occupational, speech, or audiology), personal care services, social services, general therapeutic activities, health education, nutritional meals and snacks, supervision, and protection. [WAC 388-71-0702 through 388-71-0776~~])) A supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to the core services of adult day care. Adult day health services are for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician or ARNP. [WAC 388-71-0706, 388-71-0710, 388-71-0712, 388-71-0714, 388-71-0720, 388-71-0722, 388-71-0726 and 388-71-0758]

(b) **Ambulance**—Emergency medical transportation and ambulance transportation for nonemergency medical needs. [WAC 388-546-0001 through 388-546-4000]

(c) **Blood processing/administration**—Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. [WAC 388-550-1400 and 388-550-1500]

(d) **Dental services**—Diagnosis and treatment of dental problems including emergency treatment and preventive care. [Chapters 388-535 and 388-535A WAC]

(e) **Detoxification**—Inpatient treatment performed by a certified detoxification center or in an inpatient hospital setting. [WAC 388-800-0020 through 388-800-0035; and 388-550-1100]

(f) **Diagnostic services**—Clinical testing and imaging services. [WAC 388-531-0100; 388-550-1400 and 388-550-1500]

(g) ((~~**Family planning services**—Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. [WAC 388-532-530]~~

~~(h)~~)) **Healthcare professional services**—Office visits, emergency room, nursing facility, home-based, and hospital-based care; surgery, anesthesia, pathology, radiology, and laboratory services; obstetric services; kidney dialysis and renal disease services; osteopathic care, podiatry services, physiatry, and pulmonary/respiratory services; and allergen immunotherapy. [Chapter 388-531 WAC]

((~~(i)~~)) (h) **Hearing ((~~care~~)) evaluations**—Audiology; diagnostic evaluations; hearing exams and testing((~~; and hearing aids~~)). [WAC ((~~388-544-1200 and 388-544-1300; 388-545-700; and~~)) 388-531-0100 and 388-531-0375]

(i) **Hearing aids**—[chapter 388-547 WAC]

(j) **Home health services**—Intermittent, short-term skilled nursing care, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. [WAC 388-551-2000 through 388-551-2220]

(k) **Hospice services**—Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. [WAC 388-551-1210 through 388-551-1850]

(l) **Hospital services—Inpatient/outpatient**—Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. [Chapter 388-550 WAC]

(m) **Intermediate care facility/services for mentally retarded**—Habilitative training, health-related care, supervision, and residential care. [Chapter 388-835 WAC]

(n) **Maternity care and delivery services**—Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, family planning services and community health worker visits. [WAC ((~~388-533-0330~~)) 388-533-0300]

(o) **Medical equipment, durable (DME)**—Wheelchairs, hospital beds, respiratory equipment; prosthetic and orthotic devices; casts, splints, crutches, trusses, and braces. [WAC 388-543-1100]

(p) **Medical equipment, nondurable (MSE)**—Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, transcutaneous electrical nerve stimulators (TENS) supplies, and urological supplies. [WAC 388-543-2800]

(q) **Medical nutrition services**—Enteral and parenteral nutrition, including supplies. [Chapters 388-553 and 388-554 WAC]

(r) **Mental health services**—((~~Inpatient and outpatient psychiatric services and community mental health services. [Chapter 388-865 WAC]~~)) Crisis mental health services are available to state residents through the regional support networks (RSNs).

(i) Inpatient care—Voluntary and involuntary admissions for psychiatric services. [WAC 388-550-2600]

(ii) **Outpatient (community mental health) services**—Nonemergency, nonurgent counseling. [WAC 388-531-1400, 388-865-0215, and 388-865-0230]

(iii) **Psychiatrist visits**—[WAC 388-531-1400 and 388-865-0230]

(iv) Medication management—[WAC 388-531-1400]

(s) **Nursing facility services**—Nursing, therapies, dietary, and daily care services. [Chapter 388-97 WAC]

(t) **Organ transplants**—Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. [WAC 388-550-1900 and 388-550-2000, and 388-556-0400]

(u) **Out-of-state services**—((~~Emergency services; prior authorized care. Services provided in bordering cities are treated as if they were provided in state. [WAC 388-501-0175 and 388-501-0180; 388-531-1100; and 388-556-0500]~~)) See WAC 388-502-0120 for payment of services out-of-state.

(v) **Oxygen/respiratory services**—Oxygen, oxygen equipment and supplies; oxygen and respiratory therapy, equipment, and supplies. [Chapter 388-552 WAC]

(w) **Personal care services**—Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). [WAC ((~~388-106-0010, [388-106-]0300, [388-106-]0400, [388-106-]0500, [388-106-]0600, [388-106-]0700, [388-106-]0720 and [388-106-]0900~~)) 388-106-0010, 388-106-0200, 388-106-0300, 388-106-0400, 388-106-0500, 388-106-0700, 388-106-0720 and 388-106-0745]

(x) **Prescription drugs**—Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. [WAC 388-530-1100] Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(y) **Private duty nursing**—Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. [WAC 388-551-3000.] For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(z) **Prosthetic/orthotic devices**—Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. [WAC 388-543-1100]

(aa) ((~~**School medical services**—Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). [Chapter 388-537 WAC]~~

~~(bb)~~)) **Psychological evaluation**—Complete diagnostic history, examination, and assessment, including the testing of cognitive processes, visual motor responses, and abstract abilities. [WAC 388-865-0610]

(bb) **Reproductive health services**—Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. [WAC 388-532-530]

(cc) **Substance abuse services**—Chemical dependency assessment, case management services, and treatment services. [WAC 388-533-0701 through 388-533-0730; 388-556-0100 and 388-556-0400; and 388-800-0020]

((~~(ee)~~)) (dd) **Therapy—Occupational/physical/ speech**—Evaluations, assessments, and treatment. [WAC ((~~388-545-300, 388-545-500, and 388-545-700~~)) 388-531-1725 and chapter 388-545 WAC]

((~~(dd)~~)) (ee) **Vision care**—Eye exams, refractions, ((~~frames, lenses~~)) fittings, visual field testing, vision therapy, ocular prosthetics, and surgery. [WAC ((~~388-544-0250 through 388-544-0550~~)) 388-531-1000]

(ff) **Vision hardware - frames and lenses**—[Chapter 388-544 WAC]

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.

AMENDATORY SECTION (Amending WSR 09-23-112, filed 11/18/09, effective 12/19/09)

WAC 388-501-0070 Healthcare coverage—Noncovered services. (1) The department does not pay for any healthcare service not listed or referred to as a covered healthcare service under the medical programs described in WAC 388-501-0060, regardless of medical necessity. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. Circumstances in which clients are responsible for payment of healthcare services are described in WAC 388-502-0160.

(2) This section does not apply to healthcare services provided as a result of the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter 388-534 WAC.

(3) The department does not pay for any ancillary healthcare service(s) provided in association with a noncovered healthcare service.

(4) The following list of noncovered healthcare services is not intended to be exhaustive. Noncovered healthcare services include, but are not limited to:

(a) Any healthcare service specifically excluded by federal or state law;

(b) Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, naturopathy, and sanipractice;

(c) Chiropractic care for adults;

(d) Cosmetic, reconstructive, or plastic surgery, and any related healthcare services, not specifically allowed under WAC 388-531-0100(4).

(e) Discography;

(f) Ear or other body piercing;

(g) Face lifts or other facial cosmetic enhancements;

(h) Fertility, infertility or sexual dysfunction testing, and related care, drugs, and/or treatment including but not limited to:

(i) Artificial insemination;

(ii) Donor ovum, sperm, or surrogate womb;

(iii) In vitro fertilization;

(iv) Penile implants;

(v) Reversal of sterilization; and

(vi) Sex therapy.

(i) Gender reassignment surgery and any surgery related to trans-sexualism, gender identity disorders, and body dysmorphism, and related healthcare services or procedures,

including construction of internal or external genitalia, breast augmentation, or mammoplasty;

(j) Hair transplants, epilation (hair removal), and electrolysis;

(k) Marital counseling;

(l) Motion analysis, athletic training evaluation, work hardening condition, high altitude simulation test, and health and behavior assessment;

(m) Nonmedical equipment;

(n) Penile implants;

(o) Prosthetic testicles;

(p) Psychiatric sleep therapy;

(q) Subcutaneous injection filling;

(r) Tattoo removal;

(s) Transport of Involuntary Treatment Act (ITA) clients to or from out-of-state treatment facilities, including those in bordering cities;

(t) Upright magnetic resonance imaging (MRI); and

(u) Vehicle purchase - new or used vehicle.

(5) For a specific list of noncovered healthcare services in the following service categories, refer to the WAC citation:

(a) Ambulance transportation and nonemergent transportation as described in chapter 388-546 WAC;

(b) Dental services for clients twenty years of age and younger as described in chapter 388-535 WAC;

(c) ((~~Dental services for clients twenty-one years of age and older as described in chapter 388-535 WAC;~~

~~(d)~~)) Durable medical equipment as described in chapter 388-543 WAC;

(((~~(e)~~))) (d) Hearing ((~~care services~~)) aids for clients twenty years of age and younger as described in chapter 388-547 WAC;

(((~~(f)~~))) (e) Home health services as described in WAC 388-551-2130;

(((~~(g)~~))) (f) Hospital services as described in WAC 388-550-1600;

(((~~(h)~~))) (g) Physician-related services as described in WAC 388-531-0150;

(((~~(i)~~))) (h) Prescription drugs as described in chapter 388-530 WAC; ((~~and~~))

(((~~(j)~~))) (i) Vision care ((~~services~~)) hardware for clients twenty years of age and younger as described in chapter 388-544 WAC; and

(j) Vision care exams as described in WAC 388-531-1000.

(6) A client has a right to request an administrative hearing, if one is available under state and federal law. When the department denies all or part of a request for a noncovered healthcare service(s), the department sends the client and the provider written notice, within ten business days of the date the decision is made, that includes:

(a) A statement of the action the department intends to take;

(b) Reference to the specific WAC provision upon which the denial is based;

(c) Sufficient detail to enable the recipient to:

(i) Learn why the department's action was taken; and

(ii) Prepare a response to the department's decision to classify the requested healthcare service as noncovered.

(d) The specific factual basis for the intended action; and

(e) The following information:

(i) Administrative hearing rights;

(ii) Instructions on how to request the hearing;

(iii) Acknowledgement that a client may be represented at the hearing by legal counsel or other representative;

(iv) Instructions on how to request an exception to rule (ETR);

(v) Information regarding department-covered healthcare services, if any, as an alternative to the requested noncovered healthcare service; and

(vi) Upon the client's request, the name and address of the nearest legal services office.

(7) A client can request an exception to rule (ETR) as described in WAC 388-501-0160.

AMENDATORY SECTION (Amending WSR 10-19-057, filed 9/14/10, effective 10/15/10)

WAC 388-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

(a) Fee-for-service or managed care clients can choose to self-pay for medical assistance services; and

(b) Providers (as defined in WAC 388-500-0005) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

(a) Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

(b) Verifying whether the client is enrolled with a department-contracted managed care organization (MCO);

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 388-501-0050 (4)(a) and 388-501-0065);

(d) Informing the client of those limitations;

(e) Exhausting all applicable department or department-contracted MCO processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by the department or department-contracted MCO for medical assistance services furnished to clients. See 42 CFR § 447.15.

(4) A provider must not bill a client, or anyone on the client's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in department's rules, the department's fee-for-service billing instructions, and the requirements for billing the department-contracted MCO in which the client is enrolled, and until the provider has then fully informed the client of his or her covered options. A provider must not bill a client for:

(a) Any services for which the provider failed to satisfy the conditions of payment described in department's rules, the department's fee-for-service billing instructions, and the

requirements for billing the department-contracted MCO in which the client is enrolled.

(b) A covered service even if the provider has not received payment from the department or the client's MCO.

(c) A covered service when the department denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC 388-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC ((~~388-501-0050(9)~~)) 388-501-0050(10), or a noncovered service, defined in WAC ((~~388-501-0050(10)~~)) 388-501-0050(11) and 388-501-0070. The client and provider must sign and date the DSHS form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. DSHS form 13-879, including translated versions, is available to download at http://www1.dshs.wa.gov/msa/forms/eforms.html. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than ninety calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the department or department-contracted MCO;

(iv) Specify the total amount the client must pay for the service;

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC 388-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the client has been fully informed of all available medically appropriate treatment, including services that may be paid for by the department or department-contracted MCO, and that he or she chooses to get the specified service(s);

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC 388-501-0160 when the department denies a request for a noncovered service and that the client may choose not to do so;

(viii) Specify that the client may request an administrative hearing in accordance with WAC 388-526-2610 to appeal the department's denial of a request for prior authorization of a covered service and that the client may choose not to do so;

(ix) Be completed only after the provider and the client have exhausted all applicable department or department-contracted MCO processes necessary to obtain authorization of the requested service, except that the client may choose not to request an ETR or an administrative hearing regarding department denials of authorization for requested service(s); and

(x) Specify which reason in subsection (b) below applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the client is agreeing to be billed for the service(s). The service(s) is:

(i) Not covered by the department or the client's department-contracted MCO and the ETR process as described in WAC 388-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the department or the client's department-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC 388-501-0160;

(iii) Covered by the department or the client's department-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the department denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 388-501-0169); or

(iv) Covered by the department or the client's department-contracted MCO and does not require authorization, but the client has requested a specific type of treatment, supply, or equipment based on personal preference which the department or MCO does not pay for and the specific type is not medically necessary for the client.

(c) For clients with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it;

(d) The provider must give the client a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the client's file for six years from the date of service. The agreement must be made available to the department for review upon request; and

(e) If the service is not provided within ninety calendar days of the signed agreement, a new agreement must be completed by the provider and signed by both the provider and the client.

(6) There are limited circumstances in which a provider may bill a client without executing DSHS form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section. The following are those circumstances:

(a) The client, the client's legal guardian, or the client's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 388-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.

(b) The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a medical assistance program. In this circumstance, the provider must:

(i) Keep documentation of the client's declaration of medical coverage. The client's declaration must be signed and dated by the client, the client's legal guardian, or the client's legal representative; and

(ii) Give a copy of the document to the client and maintain the original for six years from the date of service, for department review upon request.

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required

by the department). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is under the department's or a department-contracted MCO's patient review and coordination (PRC) program (WAC 388-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC 388-530-7700 (2)(a)(iii) are met;

(f) The services provided to a TAKE CHARGE or family planning only client are not within the scope of the client's benefit package;

(g) The services were noncovered ambulance services (see WAC 388-546-0250(2));

(h) A fee-for-service client chooses to receive nonemergency services from a provider who is not contracted with the department after being informed by the provider that he or she is not contracted with the department and that the services offered will not be paid by the client's healthcare program; ((~~and~~))

(i) A department-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO, i.e., a nonparticipating provider; and

(j) The service is within a service category excluded from the client's benefits package. See WAC 388-501-0060.

(7) Under chapter 388-519 WAC, an individual who has applied for medical assistance is required to spend down excess income on healthcare expenses to become eligible for coverage under the medically needy program. An individual must incur healthcare expenses greater than or equal to the amount that he or she must spend down. The provider is prohibited from billing the individual for any amount in excess of the spenddown liability assigned to the bill.

(8) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an individual and then bill the department for the covered service that had been furnished. In these situations, the individual becomes eligible for a covered service that had already been furnished. Providers must then accept as payment in full the amount paid by the department or managed care organization for medical assistance services furnished to clients. These situations are as follows:

(a) The individual was not receiving medical assistance on the day the service was furnished. The individual applies for medical assistance later in the same month in which the service was provided and the department makes the individual eligible for medical assistance from the first day of that month;

(b) The client receives a delayed certification for medical assistance as defined in WAC 388-500-0005; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 CFR § 435.914 (a) and defined in WAC 388-500-0005.

(9) Regardless of any written, signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from a client, anyone on the client's behalf, or the department for:

(a) Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, cancelled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

WSR 11-02-027
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:26 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating optional medical services from program benefit packages for clients twenty-one years of age and older. These medical services include vision, hearing, and dental. Chapter 388-531 WAC is being amended to include medical services previously listed in the programs to be eliminated that are necessary to, and included within, appropriate mandatory medical services under federal statutes and rules.

Citation of Existing Rules Affected by this Order: Amending WAC 388-531-0100, 388-531-0150, 388-531-0200, 388-531-0250, 388-531-0400, 388-531-1000, and 388-531-1300.

Statutory Authority for Adoption: RCW 74.08.090.

Other Authority: Section 209(1), chapter 37, Laws of 2010 (ESSB 6444).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 7, 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: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-12-030, filed 5/29/08, effective 7/1/08)

WAC 388-531-0100 Scope of coverage for physician-related and healthcare professional services—General and administrative. (1) The department covers healthcare services, equipment, and supplies listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060 and 388-501-0065; and

(b) Medically necessary as defined in WAC 388-500-0005.

(2) The department evaluates a request for a service that is in a covered category under the provisions of WAC 388-501-0165.

(3) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(4) The department covers the following physician-related services and healthcare professional services, subject to the conditions in subsections (1), (2), and (3) of this section:

(a) Allergen immunotherapy services;

(b) Anesthesia services;

(c) Dialysis and end stage renal disease services (refer to chapter 388-540 WAC);

(d) Emergency physician services;

(e) ENT (ear, nose, and throat) related services;

(f) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 388-534-0100);

(g) ((~~Family planning~~)) Reproductive health services (refer to chapter 388-532 WAC);

(h) Hospital inpatient services (refer to chapter 388-550 WAC);

(i) Maternity care, delivery, and newborn care services (refer to chapter 388-533 WAC);

(j) Office visits;

(k) Vision-related services((~~,~~)) (refer to chapter 388-544 WAC for vision hardware for clients twenty years of age and younger);

(l) Osteopathic treatment services;

(m) Pathology and laboratory services;

(n) Physiatry and other rehabilitation services (refer to chapter 388-550 WAC);

(o) Foot care and podiatry services (refer to WAC 388-531-1300);

(p) Primary care services;

(q) Psychiatric services, provided by a psychiatrist;

(r) Psychotherapy services for children as provided in WAC 388-531-1400;

(s) Pulmonary and respiratory services;

(t) Radiology services;

(u) Surgical services;

(v) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment; ((~~and~~))

(w) Oral healthcare services for emergency conditions for clients twenty-one years of age and older, except for clients of the division of developmental disabilities (refer to WAC 388-531-1025); and

(x) Other outpatient physician services.

(5) The department covers physical examinations for medical assistance clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 388-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(6) By providing covered services to a client eligible for a medical assistance program, a provider who has signed an agreement with the department accepts the department's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and department issuances.

AMENDATORY SECTION (Amending WSR 10-19-057, filed 9/14/10, effective 10/15/10)

WAC 388-531-0150 Noncovered physician-related and healthcare professional services—General and administrative. (1) Except as provided in WAC 388-531-

0100 and subsection (2) of this section, the department does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when the department determines that less costly, equally effective services are available;

(i) Vision-related services ((~~listed~~)) as ((~~noncovered in chapter 388-544 WAC;~~)) follows:

(i) Services for cosmetic purposes only;

(ii) Group vision screening for eyeglasses;

(iii) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens correction. This does not include intraocular lens implantation following cataract surgery.

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) ((~~Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is~~)) Foot care to treat chronic acquired conditions of the foot such as, but not limited to:

(i) Treatment of ((~~mycotic disease~~)) tinea pedis;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other regular hygiene care; ((~~or~~))

(iv) Treatment of flat feet;

(v) Treatment of high arches (cavus foot);

(vi) Onychomycosis;

(vii) Bunions and tailor's bunion (hallux valgus);

(viii) Hallux malleus;

(ix) Equinus deformity of foot, acquired;

(x) Cavovarus deformity, acquired;

(xi) Adult acquired flatfoot (metatarsus adductus or pes planus);

(xii) Hallux limitus.

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services.

(o) Nonmedical equipment; ((~~and~~))

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas;

(q) Bilateral cochlear implantation; and

(r) Routine or nonemergency medical and surgical dental services provided by a doctor of dental medicine or dental surgery for clients twenty one years of age and older, except for clients of the division of developmental disabilities.

(2) The department covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified **medicare** beneficiaries (QMBs); or

(c) A waiver program.

AMENDATORY SECTION (Amending WSR 10-19-057, filed 9/14/10, effective 10/15/10)

WAC 388-531-0200 Physician-related and health-care professional services requiring prior authorization. (1) The department requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE).** See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in the department's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to the department showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in the department billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for ((~~gynecomastia~~)) gyncomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) The department evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R);**

(c) Unilateral cochlear implants((~~, which also:~~

~~(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and~~

~~(ii) For reimbursement, must have the invoice attached to the claim~~)) for clients twenty years of age and younger (refer to WAC 388-531-0375);

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

(e) Osteopathic manipulative therapy in excess of the department's published limits;

(f) Panniculectomy;

(g) Bariatric surgery (see WAC 388-531-1600); and

(h) Vagus nerve stimulator insertion, which also:

(i) For coverage, must be performed in an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim.

(i) Osseointegrated/bone anchored hearing aids (BAHA) for clients twenty years of age and younger;

(j) Removal or repair of previously implanted BAHA or cochlear device for clients twenty one years of age and older when medically necessary.

(5) The department may require a second opinion and/or consultation before authorizing any elective surgical procedure.

(6) Children six ((~~year~~)) years of age and younger do not require authorization for hospitalization.

AMENDATORY SECTION (Amending WSR 08-12-030, filed 5/29/08, effective 7/1/08)

WAC 388-531-0250 Who can provide and bill for physician-related and healthcare professional services. (1) The following enrolled providers are eligible to provide and bill for physician-related and healthcare professional services which they provide to eligible clients:

(a) Advanced registered nurse practitioners (ARNP);

(b) Federally qualified health centers (FQHCs);

(c) Health departments;

(d) Hospitals currently licensed by the department of health;

(e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;

(f) Licensed marriage and family therapists, only as provided in WAC 388-531-1400;

(g) Licensed mental health counselors, only as provided in WAC 388-531-1400;

(h) Licensed radiology facilities;

(i) Licensed social workers, only as provided in WAC 388-531-1400 and 388-531-1600;

(j) Medicare-certified ambulatory surgery centers;

(k) Medicare-certified rural health clinics;

(l) Providers who have a signed agreement with the department to provide screening services to eligible persons in the EPSDT program;

(m) Registered nurse first assistants (RNFA); and

(n) Persons currently licensed by the state of Washington department of health to practice any of the following:

(i) Dentistry (refer to chapter 388-535 WAC);

(ii) Medicine and osteopathy;

(iii) Nursing;

(iv) Optometry; or

(v) Podiatry.

(2) The department does not pay for services performed by any of the following practitioners:

(a) Acupuncturists;

(b) Christian Science practitioners or theological healers;

(c) Counselors, except as provided in WAC 388-531-1400;

(d) Herbalists;

(e) Homeopaths;

(f) Massage therapists as licensed by the Washington state department of health;

(g) Naturopaths;

(h) Sanipractors;

(i) Social workers, except those who have a master's degree in social work (MSW), and:

(i) Are employed by an FQHC;

(ii) Who have prior authorization to evaluate a client for bariatric surgery; or

(iii) As provided in WAC 388-531-1400.

(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or

(k) Any other licensed practitioners providing services which the practitioner is not:

(i) Licensed to provide; and

(ii) Trained to provide.

(3) The department pays practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:

(a) The EPSDT program;

(b) A medicaid program for qualified medicare beneficiaries (QMB); or

(c) A waiver program.

NEW SECTION

WAC 388-531-0375 Audiology services. (1) The department covers, with prior authorization, the implantation of a unilateral cochlear device for clients twenty years of age and younger with the following limitations:

(a) The client meets one of the following:

(i) Has a diagnosis of profound to severe bilateral, sensorineural hearing loss;

(ii) Has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to forty percent correct in the best-aided condition on recorded open-set sentence recognition tests);

(iii) Has the cognitive ability to use auditory clues;

(iv) Is willing to undergo an extensive rehabilitation program;

(v) Has an accessible cochlear lumen that is structurally suitable for cochlear implantation;

(vi) Does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; or

(vii) Has no other contraindications to surgery; and

(b) The procedure is performed in an inpatient hospital setting or outpatient hospital setting.

(2) The department covers osseointegrated bone anchored hearing aids (BAHA) for clients twenty years of age and younger with prior authorization.

(3) The department covers replacement parts for BAHA and cochlear devices for clients twenty years of age and younger only. See WAC 388-547-0800.

(4) The department considers requests for removal or repair of previously implanted bone anchored hearing aids (BAHA) and cochlear devices for clients twenty one years of age and older only when medically necessary. Prior authorization from the department is required.

(5) For audiology, the department limits:

(a) Caloric vestibular testing to four units for each ear; and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

AMENDATORY SECTION (Amending WSR 01-01-012, filed 12/6/00, effective 1/6/01)

WAC 388-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC ((~~388-501-0100~~)) 388-502-0100, for noncovered services ((~~that are not covered under the client's medical care program~~)) as defined in WAC 388-501-0050 or for services excluded from the client's benefits package as defined under WAC 388-501-0060. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

AMENDATORY SECTION (Amending WSR 01-01-012, filed 12/6/00, effective 1/6/01)

WAC 388-531-1000 Ophthalmic ((~~physician-related~~)) services. Refer to chapter 388-544 WAC for ((~~ophthalmic and~~)) vision-related ((~~services~~)) hardware coverage for clients twenty years of age and younger.

(1) The department covers, without prior authorization, eye examinations, refraction and fitting services with the following limitations:

(a) Once every twenty four months for asymptomatic clients twenty one years of age or older;

(b) Once every twelve months for asymptomatic clients twenty years of age or younger; or

(c) Once every twelve months, regardless of age, for asymptomatic clients of the division of developmental disabilities.

(2) The department covers additional examinations and refraction services outside the limitations described in subsection (1) of this section when:

(a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;

(b) The client is on medication that affects vision; or

(c) The service is necessary due to lost or broken eyeglasses/contacts. In this case:

(i) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.

(ii) Providers must follow the department's expedited prior authorization process to receive payment for clients twenty one years of age or older. Providers must also document the following in the client's file:

(A) The eyeglasses or contacts are lost or broken; and

(B) The last examination was at least eighteen months ago.

(3) The department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

(4) The department covers orthoptics and vision training therapy. Providers must obtain prior authorization from the department.

(5) The department covers ocular prosthetics for clients when provided by any of the following:

(a) An ophthalmologist;

(b) An ocularist; or

(c) An optometrist who specializes in prosthetics.

(6) The department covers cataract surgery, without prior authorization when the following clinical criteria are met:

(a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

(b) One or more of the following conditions:

(i) Dislocated or subluxated lens;

(ii) Intraocular foreign body;

(iii) Ocular trauma;

(iv) Phacogenic glaucoma;

(v) Phacogenic uveitis;

(vi) Phacoanaphylactic endopthalmitis; or

(vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.

(7) The department covers strabismus surgery as follows:

(a) For clients seventeen years of age and younger. The provider must clearly document the need in the client's record. The department does not require authorization for clients seventeen years of age and younger; and

(b) For clients eighteen years of age and older, when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

(i) The client has double vision; and

(ii) The surgery is not being performed for cosmetic reasons.

(8) The department covers blepharoplasty or blepharoptosis surgery for clients when all of the clinical criteria are met. To receive payment, providers must follow the department's expedited prior authorization process. The clinical criteria are:

(a) The client's excess upper eyelid skin is blocking the superior visual field; and

(b) The blocked vision is within ten degrees of central fixation using a central visual field test.

NEW SECTION

WAC 388-531-1025 Oral healthcare services provided by dentists for clients age twenty-one and older—General. This section does not apply to clients of the division of developmental disabilities. Refer to WAC 388-535-1099.

(1) Clients age twenty-one and older are eligible for the oral healthcare services listed in this section, subject to coverage limitations. The department pays for oral healthcare services provided by a dentist to clients age twenty-one and older when the services provided:

(a) Are within the scope of the eligible client's medical care program;

(b) Are medically necessary as defined in WAC 388-500-0005;

(c) Are emergent and meets the criteria of coverage for emergency oral healthcare benefit listed in subsection (7) of this section;

(d) Are documented in the client's record in accordance with chapter 388-502 WAC;

(e) Meet the department's prior authorization requirements, if there are any;

(f) Are within prevailing standard of care accepted practice standards;

(g) Are consistent with a diagnosis of teeth, mouth and jaw disease or condition;

(h) Are reasonable in amount and duration of care, treatment, or service;

(i) Are billed using only the allowed procedure codes listed in the department's published billing instructions and fee schedules; and

(j) Are documented with a comprehensive description of the client's presenting symptoms, diagnosis and services provided, in the client's record, including the following, if applicable:

(i) Client's blood pressure, when appropriate;

(ii) A surgical narrative;

(iii) A copy of the post-operative instructions; and

(iv) A copy of all pre- and post-operative prescriptions.

(2) An appropriate consent form, if required, signed and dated by the client or the client's legal representative must be in the client's record.

(3) An anesthesiologist providing oral healthcare under this section must have a current provider's permit on file with the department.

(4) A healthcare provider providing oral or parenteral conscious sedation, or general anesthesia, must meet:

(a) The provider's professional organization guidelines;

(b) The department of health (DOH) requirements in chapter 246-817 WAC; and

(c) Any applicable DOH medical, dental, and nursing anesthesia regulations.

(5) Department-enrolled dental providers who are not specialized to perform oral and maxillofacial surgery (see WAC 388-535-1070(3)) must use only the current dental terminology (CDT) codes to bill claims for services that are listed in this section.

(6) Oral healthcare services must be provided in a clinic setting with the exception of trauma related services.

(7) Emergency oral healthcare benefit.

(a) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, are considered a physician service, are included in the emergency oral healthcare benefit when the services are done emergently. All services are subject to prior authorization when indicated.

(b) The following set of services are covered under the emergency oral healthcare benefit when provided by a dentist to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pre-transplant protocol:

(i) One emergency examination, per presenting problem, performed as a limited oral evaluation to:

(A) Evaluate the client's symptom of pain;

(B) Make a diagnosis; and

(C) Develop or implement a treatment plan, including a referral to another healthcare professional, such as an oral surgeon; or

(D) A second evaluation if the treatment initiated is conservative, such as prescribed antibiotics, and a subsequent visit is necessary for definitive treatment, such as tooth extraction. The treatment plan must be documented in the client's record.

(ii) Diagnostic radiographs (xrays).

(A) Radiographs include:

(I) Periapical; and

(II) Panoramic films, limited to one every three years.

(B) Radiographs must:

(I) Be required to make the diagnosis;

(II) Support medical necessity;

(III) Be of diagnostic quality, dated and labeled with the client's name;

(IV) Be retained by the provider as part of the client's record. The retained radiograph must be the original.

(C) Duplicate radiographs must be submitted with prior authorization requests or when the department requests a copy of the client's dental record.

(iii) Pulpal debridement. One gross pulpal debridement per client, per tooth, within a twelve-month period.

(iv) Extractions and surgical extractions for symptomatic teeth, limited to:

(A) Extraction of a nearly-erupted or fully erupted tooth or exposed root;

(B) Surgical removal of an erupted tooth only;

(C) Surgical removal of residual tooth roots; and

(D) Extraction of an impacted wisdom tooth when the tooth is not erupted.

(v) Palliative (emergency) treatment for the treatment of dental pain, one per client, per six-month period, during a limited oral evaluation appointment.

(vi) Local anesthesia and regional blocks as part of the global fee for any procedure being provided to a client.

(vii) Inhalation of nitrous oxide, once per day.

(viii) House or extended care facility visits, for emergency care as defined in this section.

(ix) Emergency office visits after regularly scheduled hours. The department limits coverage to one emergency visit per day, per provider.

(x) Therapeutic drug injections including drugs and/or medicaments (pharmaceuticals) only when used with general anesthesia.

(xi) Treatment of post-surgical complications, such as dry socket.

(c) Emergency healthcare benefit services provided by dentists specialized in oral maxillofacial surgery. Services that are covered under the emergency oral healthcare benefit to assess and treat pain, infection or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket and services that are part of a cancer treatment regimen or part of a pre-transplant protocol:

(i) May be provided by dentists specialized in oral maxillofacial surgery; and

(ii) Are billed using only the allowed procedure codes listed in the department's published billing instructions and fee schedules.

(8) Prior Authorization for oral healthcare services provided by dentists for clients age twenty-one and older.

(a) The department uses the determination process described in WAC 388-501-0165 for covered oral healthcare services for clients age twenty-one and older for an emergent condition that requires prior authorization.

(b) The department requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on the DSHS 13-835 general information for authorization form which may be obtained at http://dshs.wa.gov/msa/forms/eforms.html.

(c) The department may request additional information as follows:

(i) Additional radiographs (X rays);

(ii) Study models;

(iii) Photographs; and

(iv) Any other information as determined by the department.

(d) The department may require second opinions and/or consultations before authorizing any procedure.

(e) When the department authorizes an oral healthcare service for a client, that authorization indicates only that the specific service is medically necessary and emergent, it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible and the service is covered in the client's healthcare benefit package on the date of service.

(f) The department denies a request for an oral healthcare service when the requested service:

(i) Is not covered in the client's healthcare benefit package;

(ii) Is covered by another department program;

(iii) Is covered by an agency or other entity outside the department; or

(iv) Fails to meet the clinical criteria, limitations, or restrictions in this section.

(9) Refer to chapter 388-535 WAC and WAC 388-531-1850 and 388-531-1900 for the payment methodologies used for the services listed in this section.

AMENDATORY SECTION (Amending WSR 10-19-057, filed 9/14/10, effective 10/15/10)

WAC 388-531-1300 Foot care and podiatric ((~~physician-related~~)) services. (1) The department covers the foot care and podiatric services as listed in this section when those services are provided by any of the following healthcare providers and billed to the department using procedure codes and diagnosis codes that are within their scope of practice:

(a) A ((~~medical doctor~~)) physician or physician's assistant (PA-C);

(b) A doctor of osteopathy or osteopathic physician's assistant (PA-C); ((~~or~~))

(c) A podiatric physician; or

(d) Advanced registered nurse practitioner (ARNP).

(2) The department ((~~reimburses~~)) pays for ((~~the following~~)):

(a) ((~~Nonroutine~~)) Foot care ((~~when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;~~)) as follows:

(i) Office visits to diagnose acute conditions and acquired chronic conditions of the lower extremities. Once diagnosis is made, the department will pay for treatment.

(ii) Treatment of acute conditions only of the lower extremities, to include but not limited to:

(A) Neuropathies, e.g., reflex sympathetic dystrophy or as a result of diabetes;

(B) Circulatory compromise such as, but are not limited to:

(I) Lymphedemia;

(II) Raynaud's disease;

(III) Thromoangiitis obliterans; and

(IV) Phlebitis.

(C) Ulcerations;

(D) Lacerations, wounds, blisters;

(E) Fractures, sprains, injuries, wounds;

(F) Soft tissue tumors;

(G) Gout;

(H) Post-op complications;

(I) Tarsal tunnel syndrome;

(J) Acute inflammatory processes such as, but not limited to tendonitis;

(K) Bone spurs;

(L) Osteomyelitis; and

(M) Soft tissue conditions, such as, but are not limited to:

(I) Rashes;

(II) Infection;

(III) Gangrene;

(IV) Cellulitis of lower extremities; or

(V) Infection within nail beds (paronychia).

(iii) The department does not pay for treatment of chronic acquired conditions of the lower extremities. The department will pay for prescriptions as allowed under chapter 388-530 WAC outpatient prescription drugs.

(b) Debridement of nails to treat one of the acute conditions in subsection (2)(a)(ii) of this section. The department pays for one treatment in a sixty-day period ((~~for debridement of nails~~)). The department covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting to treat one of the acute conditions in subsection (2)(a)(ii) of this section. The department includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure to treat one of the acute conditions in subsection (2)(a)(ii) of this section performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. The department does not ((~~reimburse~~)) separately pay for ((~~the~~)) anesthesia((~~, but includes it~~)) as it is included in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices to treat one of the acute conditions in subsection (2)(a)(ii) of this section:

(i) The department's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) The department includes an evaluation and management (E&M) fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) The department does not ((~~reimburse podiatrists~~)) pay any provider for ((~~any of~~)) the following radiology services to diagnose conditions of the lower extremities:

(a) ((~~X rays for soft tissue diagnosis;~~

~~(b)~~)) Bilateral X rays for a unilateral condition; or

(((~~(c)~~))) (b) X rays in excess of ((~~two~~)) three views; or

(((~~(d)~~))) (c) X rays that are ordered before the client is examined((~~; or~~

~~(e) X rays for any part of the body other than the foot or ankle~~)).

(4) The department does not pay podiatrists for X rays for any part of the body other than the foot or ankle.

WSR 11-02-030
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:38 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s): Nonemergency dental and dental-related services for clients age twenty-one and older.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-535-1247, 388-535-1255, 388-535-1257, 388-535-1259, 388-535-1261, 388-535-1263, 388-535-1266, 388-535-1267, 388-535-1269, 388-535-1271 and 388-535-1280; and amending WAC 388-535-1060, 388-535-1065, 388-535-1084, 388-535-1090, 388-535-1099, 388-535-1100, 388-535-1350, 388-535-1400, 388-535-1450, 388-535-1500, and 388-535-1550.

Statutory Authority for Adoption: RCW 74.08.090.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid programs for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 11, Repealed 11.

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 11, Repealed 11.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-19-077, filed 9/12/03, effective 10/13/03)

WAC 388-535-1060 Clients who are eligible for dental-related services. ((~~The following clients who receive services under the medical assistance programs listed in this section are eligible for covered dental-related services, subject to the restrictions and specific limitations described in this chapter and other applicable WAC:~~)) This section applies to eligible clients who are twenty years of age and younger.

(1) ((~~Children eligible for the~~)) Dental-related services are available to a client age twenty years or younger who is

eligible for services under one of the following medical assistance programs:

(a) Categorically needy program (CN or CNP);

(b) Categorically needy program - children's health insurance program (CNP-CHIP); ((~~and~~))

(c) ((~~Limited casualty program –~~)) Medically needy program (((~~LCP-MNP~~))) (MNP); or

(d) Disability lifeline (formerly general assistance-unemployable (GAU) or alcohol and drug abuse treatment and support act (ADATSA).

(2) ((~~Adults eligible for the:~~

~~(a) Categorically needy program (CN or CNP); and~~

~~(b) Limited casualty program - medically needy program (LCP-MNP).~~

~~(3) Clients eligible for medical care services under the following state-funded only programs are eligible only for the limited dental-related services described in WAC 388-535-1065:~~

~~(a) General assistance - Unemployable (GA-U); and~~

~~(b) General assistance - Alcohol and Drug Abuse Treatment and Support Act (ADATSA) (GA-W).~~

~~(4)~~)) (2) Eligible clients who are enrolled in a department-contracted managed care ((~~plan~~)) organization are eligible ((~~for medical assistance administration (MAA) covered dental services that are not covered by their plan,~~)) under fee-for-service for covered services that are not covered by their plan, subject to the provisions of ((~~chapter 388-535 WAC and~~)) other applicable ((~~WAC~~)) department rules.

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 07-17-107, filed 8/17/07, effective 9/17/07)

WAC 388-535-1065 Coverage limits for dental-related services provided under the ((~~GA-U~~)) disability lifeline and ADATSA programs. This section applies only to clients who are twenty years of age and younger and eligible under the disability lifeline program (formerly general assistance-unemployable (GA-U)) and alcohol and drug abuse treatment and support act (ADATSA).

(1) ((~~Clients who receive medical care services under the following programs may receive the dental-related services described in this section:~~

~~(a) General assistance unemployable (GA-U); and~~

~~(b) Alcohol and drug abuse treatment and support act (ADATSA).~~

~~(2)~~)) The department covers the following dental-related services for a client ((~~eligible under the GA-U~~)) who is twenty years of age or younger and eligible under the disability lifeline or ADATSA program:

(a) Services provided only as part of dental treatment for:

(i) Limited oral evaluation;

(ii) Periapical or bite-wing radiographs that are medically necessary to diagnose only the client's chief complaint;

(iii) Palliative treatment to relieve dental pain;

(iv) Pulpal debridement to relieve dental pain; or

(v) Endodontic (root canal only) treatment for maxillary and mandibular anterior teeth (cuspids and incisors) when prior authorized((~~.~~)).

(b) Tooth extraction when at least one of the following apply:

(i) The tooth has a radiograph apical lesion;

(ii) The tooth is endodontically involved, infected, or abscessed;

(iii) The tooth is not restorable; or

(iv) The tooth is not periodontally stable.

(((~~3~~))) (2) Tooth extractions require prior authorization when:

(i) The extraction of a tooth or teeth results in the client becoming edentulous in the maxillary arch or mandibular arch; and

(ii) A full mouth extraction is necessary because of radiation therapy for cancer of the head and neck.

(((~~4~~))) (3) Each dental-related procedure described under this section is subject to the coverage limitations listed in chapter 388-535 WAC.

(((~~5~~))) (4) The department does not cover any dental-related services not listed in this section for ((~~clients eligible under the GA-U or ADATSA program~~)) a disability lifeline client or an ADATSA client who is twenty-one years of age or older, including any type of removable prosthesis (denture).

AMENDATORY SECTION (Amending WSR 07-06-042, filed 3/1/07, effective 4/1/07)

WAC 388-535-1084 Covered dental-related services for clients through age twenty—Restorative services. The department covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Restorative/operative procedures.** The department covers restorative/operative procedures performed in a hospital or an ambulatory surgical center for:

(a) Clients ages eight and younger;

(b) Clients ages nine through twenty only on a case-by-case basis and when prior authorized; and

(c) Clients of the division of developmental disabilities according to WAC 388-535-1099.

(2) **Amalgam restorations for primary and permanent teeth.** The department considers:

(a) Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and polishing as part of the amalgam restoration.

(b) The occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the amalgam restoration.

(c) Buccal or lingual surface amalgam restorations, regardless of size or extension, as a one surface restoration. The department covers one buccal and one lingual surface per tooth.

(d) Multiple amalgam restorations of fissures and grooves of the occlusal surface of the same tooth as a one surface restoration.

(e) Amalgam restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(3) **Amalgam restorations for primary posterior teeth only.** The department covers amalgam restorations for a

maximum of two surfaces for a primary first molar and maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this section for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional amalgam restorations.

(4) **Amalgam restorations for permanent posterior teeth only.** The department:

(a) Covers two occlusal amalgam restorations for teeth one, two, three fourteen, fifteen, and sixteen, if the restorations are anatomically separated by sound tooth structure.

(b) Covers amalgam restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

(c) Covers amalgam restorations for a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) Does not pay for replacement of amalgam restoration on permanent posterior teeth within a two-year period unless the restoration has an additional adjoining carious surface. The department pays for the replacement restoration as one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(5) **Resin-based composite restorations for primary and permanent teeth.** The department:

(a) Considers tooth preparation, acid etching, all adhesives (including resin bonding agents), liners and bases, polishing, and curing as part of the resin-based composite restoration.

(b) Considers the occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the resin-based composite restoration.

(c) Considers buccal or lingual surface resin-based composite restorations, regardless of size or extension, as a one surface restoration. The department covers only one buccal and one lingual surface per tooth.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentoenamel junction (DEJ) to be sealants (see WAC 388-535-1082(4) for sealants coverage).

(e) Considers multiple preventive restorative resin, flowable composite resin, or resin-based composites for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one surface restoration.

(f) Does not cover preventive restorative resin or flowable composite resin on the interproximal surfaces (mesial and/or distal) when performed on posterior teeth or the incisal surface of anterior teeth.

(g) Considers resin-based composite restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(6) **Resin-based composite restorations for primary teeth only.** The department covers:

(a) Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth (see subsection (9)(b) of this section for restorations for a primary anterior tooth requiring a four or more surface restoration). The department does not pay for additional composite or amalgam restorations on the same tooth after three surfaces.

(b) Resin-based composite restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. (See subsection (9)(c) of this subsection for restorations for a primary posterior tooth requiring additional surfaces.) The department does not pay for additional composite restorations on the same tooth.

(c) Glass ((~~ionimer~~)) ionomer restorations only for primary teeth, and only for clients ages five and younger. The department pays for these restorations as a one surface resin-based composite restoration.

(7) **Resin-based composite restorations for permanent teeth only.** The department covers:

(a) Two occlusal resin-based composite restorations for teeth one, two, fourteen, fifteen, and sixteen if the restorations are anatomically separated by sound tooth structure.

(b) Resin-based composite restorations for a maximum of five surfaces per tooth for a permanent posterior tooth, once per client, per provider or clinic, in a two-year period.

(c) Resin-based composite restorations for a maximum of six surfaces per tooth for permanent posterior teeth one, two, three, fourteen, fifteen, and sixteen, once per client, per provider or clinic, in a two-year period (see (a) of this subsection).

(d) Resin-based composite restorations for a maximum of six surfaces per tooth for a permanent anterior tooth, once per client, per provider or clinic, in a two-year period.

(e) Replacement of resin-based composite restoration on permanent teeth within a two-year period only if the restoration has an additional adjoining carious surface. The department pays the replacement restoration as a one multi-surface restoration. The client's record must include radiographs and documentation supporting the medical necessity for the replacement restoration.

(8) **Crowns.** The department:

(a) Covers the following crowns once every five years, per tooth, for permanent anterior teeth for clients ages twelve through twenty when the crowns meet prior authorization criteria in WAC 388-535-1220 and the provider follows the prior authorization requirements in (d) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) ((~~Covers full coverage metal crowns once every five years, per tooth, for permanent posterior teeth to include high noble, titanium, titanium alloys, noble, and predominantly base metal crowns for clients ages eighteen through twenty when they meet prior authorization criteria and the provider follows the prior authorization requirements in (d) and (e) of this subsection.~~

~~(c)~~)) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The department covers a one

surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries, including but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

((~~(d)~~)) (c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

((~~(e)~~)) (d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(9) **Other restorative services.** The department covers:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years without prior authorization if the tooth requires a four or more surface restoration.

(c) Prefabricated stainless steel crowns for primary posterior teeth once every three years without prior authorization if:

(i) Decay involves three or more surfaces for a primary first molar;

(ii) Decay involves four or more surfaces for a primary second molar; or

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns for permanent posterior teeth once every three years when prior authorized.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities according to WAC 388-535-1099.

(f) Core buildup, including pins, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, when prior authorized at the same time as the crown prior authorization.

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 07-06-042, filed 3/1/07, effective 4/1/07)

WAC 388-535-1090 Covered dental-related services for clients through age twenty—Prosthodontics (removable). The department covers medically necessary prosthodontics (removable) services, subject to the coverage limitations listed, for clients through age twenty as follows:

(1) **Prosthodontics.** The department:

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures, except as stated in (c)(ii)(B) of this subsection. Prior authorization requests must meet the criteria in WAC 388-535-1220. In addition, the department requires the dental provider to submit:

(i) Appropriate and diagnostic radiographs of all remaining teeth.

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

(C) Dental and periodontal services completed on all remaining teeth.

(iii) A prescription written by a dentist when a denturist's prior authorization request is for an immediate denture or a cast metal partial denture.

(b) Covers complete dentures, as follows:

(i) A complete denture, including an immediate denture or overdenture, is covered when prior authorized.

(ii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat (placement) date of the complete denture, is considered part of the complete denture procedure and is not paid separately.

(iii) Replacement of an immediate denture with a complete denture is covered if the complete denture is prior authorized at least six months after the seat date of the immediate denture.

(iv) Replacement of a complete denture or overdenture is covered only if prior authorized at least five years after the seat date of the complete denture or overdenture being replaced. The replacement denture must be prior authorized.

(c) Covers partial dentures, as follows:

(i) A partial denture, including a resin ((~~or flexible base~~)) partial denture, is covered for anterior and posterior teeth when the partial denture meets the following department coverage criteria.

(A) The remaining teeth in the arch must have a reasonable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) One or more anterior teeth are missing or four or more posterior teeth are missing;

(D) There is a minimum of four stable teeth remaining per arch; and

(E) There is a three-year prognosis for retention of the remaining teeth.

(ii) Prior authorization of partial dentures:

(A) Is required for clients ages nine and younger; and

(B) Not required for clients ages ten through twenty. Documentation supporting the medical necessity for the service must be included in the client's file.

(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the partial den-

ture, is considered part of the partial denture procedure and is not paid separately.

(iv) Replacement of a resin or flexible base denture is covered only if prior authorized at least three years after the seat date of the resin or flexible base partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria in (c)(i) of this subsection.

(d) Covers cast-metal framework partial dentures, as follows:

(i) Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, are covered for clients ages eighteen through twenty only once in a five-year period, on a case-by-case basis, when prior authorized and department coverage criteria listed in subsection (d)(v) of this subsection are met.

(ii) Cast-metal framework partial dentures for clients ages seventeen and younger are not covered.

(iii) Three-month post-delivery care (e.g., adjustments, soft relines, and repairs) from the seat date of the cast metal partial denture is considered part of the partial denture procedure and is not paid separately.

(iv) Replacement of a cast metal framework partial denture is covered on a case-by-case basis and only if placed at least five years after the seat date of the partial denture being replaced. The replacement denture must be prior authorized and meet department coverage criteria listed in (d)(v) of this subsection.

(v) Department authorization and payment for cast metal framework partial dentures is based on the following criteria:

(A) The remaining teeth in the arch must have a stable periodontal diagnosis and prognosis;

(B) The client has established caries control;

(C) All restorative and periodontal procedures must be completed before the request for prior authorization is submitted;

(D) There are fewer than eight posterior teeth in occlusion;

(E) There is a minimum of four stable teeth remaining per arch; and

(F) There is a five-year prognosis for the retention of the remaining teeth.

(vi) The department may consider resin partial dentures as an alternative if the department determines the criteria for cast metal framework partial dentures listed in (d)(v) of this subsection are not met.

(e) Requires a provider to bill for removable prosthetic procedures only after the seating of the prosthesis, not at the impression date. Refer to subsection (2)(e) and (f) for what the department may pay if the removable prosthesis is not delivered and inserted.

(f) Requires a provider to submit the following with a prior authorization request for removable prosthetics for a client residing in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility:

(i) The client's medical diagnosis or prognosis;

(ii) The attending physician's request for prosthetic services;

(iii) The attending dentist's or denturist's statement documenting medical necessity;

(iv) A written and signed consent for treatment from the client's legal guardian when a guardian has been appointed; and

(v) A completed copy of the denture/partial appliance request for skilled nursing facility client form (DSHS 13-788) available from the department's published billing instructions.

(g) Limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (f) of this subsection. The department may consider cast metal partial dentures if the criteria in subsection (1)(d) are met.

(h) Requires a provider to deliver services and procedures that are of acceptable quality to the department. The department may recoup payment for services that are determined to be below the standard of care or of an unacceptable product quality.

(2) **Other services for removable prosthodontics.** The department covers:

(a) Adjustments to complete and partial dentures three months after the date of delivery.

(b) Repairs to complete and partial dentures, once in a twelve month period. The cost of repairs cannot exceed the cost of replacement. The department covers additional repairs on a case-by-case basis and when prior authorized.

(c) A laboratory reline or rebase to a complete or cast-metal partial denture, once in a three-year period when performed at least six months after the seating date. An additional reline or rebase may be covered for complete or cast-metal partial dentures on a case-by-case basis when prior authorized.

(d) Up to two tissue conditionings, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

(i) The department does not pay separately for laboratory or professional fees for complete and partial dentures; and

(ii) The department may pay part of billed laboratory fees when the provider obtains prior authorization, and the client:

(A) Is not eligible at the time of delivery of the prosthesis;

(B) Moves from the state;

(C) Cannot be located;

(D) Does not participate in completing the complete, immediate, or partial dentures; or

(E) Dies.

(f) A provider must submit copies of laboratory prescriptions and receipts or invoices for each claim when billing for laboratory fees.

AMENDATORY SECTION (Amending WSR 07-06-042, filed 3/1/07, effective 4/1/07)

WAC 388-535-1099 Covered dental-related services for clients of the division of developmental disabilities. The department pays for dental-related services under the categories of services listed in this section for clients of the division of developmental disabilities, subject to the coverage limitations listed. Chapter 388-535 WAC applies to cli-

ents of the division of developmental disabilities unless otherwise stated in this section.

(1) **Preventive services.**

(a) Dental prophylaxis. The department covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).

(b) Topical fluoride treatment. The department covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

(c) Sealants. The department covers sealants:

(i) Only when used on the occlusal surfaces of:

(A) Primary teeth A, B, I, J, K, L, S, and T; or

(B) Permanent teeth two, three, four, five, twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, and thirty-one.

(ii) Once per tooth in a two-year period.

(2) **Crowns.** The department covers stainless steel crowns every two years for the same tooth and only for primary molars and permanent premolars and molars, as follows:

(a) For clients ages twenty and younger, the department does not require prior authorization for stainless steel crowns. Documentation supporting the medical necessity of the service must be in the client's record.

(b) For clients ages twenty-one and older, the department requires prior authorization for stainless steel crowns.

(3) **Periodontic services.**

(a) **Surgical periodontal services.** The department covers:

(i) Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).

(ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:

(A) In a hospital or ambulatory surgical center; or

(B) For clients under conscious sedation, deep sedation, or general anesthesia.

(b) **Nonsurgical periodontal services.** The department covers:

(i) Periodontal scaling and root planing, up to two times per quadrant in a twelve-month period.

(ii) Periodontal scaling (four quadrants) substitutes for an eligible periodontal maintenance or oral prophylaxis, twice in a twelve-month period.

(4) **Adjunctive general services.**

(a) **Adjunctive general services.** The department covers:

(i) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

(ii) Sedations services according to WAC 388-535-1098 (1)(c) and (e).

(b) **Nonemergency dental services.** The department covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 388-535-1082, 388-535-1084, 388-535-1086, 388-535-1088, and 388-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(5) **Miscellaneous services—Behavior management.** The department covers behavior management provided in dental offices or dental clinics ((~~for clients of any age~~)). Documentation supporting the medical necessity of the service must be included in the client's record.

AMENDATORY SECTION (Amending WSR 07-06-042, filed 3/1/07, effective 4/1/07)

WAC 388-535-1100 Dental-related services not covered for clients through age twenty. (1) The department does not cover the following for clients through age twenty:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC 388-534-0100 for information about the EPSDT program.

(b) Any service specifically excluded by statute.

(c) More costly services when less costly, equally effective services as determined by the department are available.

(d) Services, procedures, treatment, devices, drugs, or application of associated services:

(i) Which the department or the Centers for Medicare and Medicaid Services (CMS) considers investigative or experimental on the date the services were provided.

(ii) That are not listed as covered in one or both of the following:

(A) Washington Administrative Code (WAC).

(B) The department's current published documents.

(2) The department does not cover dental-related services listed under the following categories of service for clients through age twenty (see subsection (1)(a) of this section for services provided under the EPSDT program):

(a) **Diagnostic services.** The department does not cover:

(i) Extraoral radiographs.

(ii) Comprehensive periodontal evaluations.

(b) **Preventive services.** The department does not cover:

(i) Nutritional counseling for control of dental disease.

(ii) Tobacco counseling for the control and prevention of oral disease.

(iii) Removable space maintainers of any type.

(iv) Sealants placed on a tooth with the same-day occlusal restoration, preexisting occlusal restoration, or a tooth with occlusal decay.

(v) Space maintainers for clients ages nineteen through twenty.

(c) **Restorative services.** The department does not cover:

(i) Restorations for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface;

(ii) Gold foil restorations.

((~~(ii)~~)) (iii) Metallic, resin-based composite, or porcelain/ceramic inlay/onlay restorations.

((~~(iii)~~)) (iv) Preventive restorations.

(v) Crowns for cosmetic purposes (e.g., peg laterals and tetracycline staining).

(((~~(iv)~~))) (vi) Permanent crowns for ((~~third molars one, sixteen, seventeen, and thirty-two~~)) bicuspids or molar teeth.

(((~~(v)~~))) (vii) Temporary or provisional crowns (including ion crowns).

(((~~(vi)~~))) (viii) Labial veneer resin or porcelain laminate restorations.

(((~~(vii)~~))) (ix) Any type of coping.

(((~~(viii)~~))) (x) Crown repairs.

(((~~(ix)~~))) (xi) Polishing or recontouring restorations or overhang removal for any type of restoration.

(d) **Endodontic services.** The department does not cover:

(i) Any endodontic therapy on primary teeth, except as described in WAC 388-535-1086 (3)(a).

(ii) Apexification/recalcification for root resorption of permanent anterior teeth.

(iii) Any apexification/recalcification procedures for bicuspid or molar teeth.

(iv) Any apicoectomy/periradicular services for bicuspid or molar teeth.

(v) Any surgical endodontic procedures including, but not limited to, retrograde fillings (except for anterior teeth), root amputation, reimplantation, and hemisections.

(e) **Periodontic services.** The department does not cover:

(i) Surgical periodontal services including, but not limited to:

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

(E) Biological material to aid in soft and osseous tissue regeneration.

(F) Guided tissue regeneration.

(G) Pedicle, free soft tissue, apical positioning, subepithelial connective tissue, soft tissue allograft, combined connective tissue and double pedicle, or any other soft tissue or osseous grafts.

(H) Distal or proximal wedge procedures.

(ii) Nonsurgical periodontal services including, but not limited to:

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement.

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

(f) **Removable prosthodontics.** The department does not cover:

(i) Removable unilateral partial dentures.

(ii) Any interim complete or partial dentures.

(iii) Flexible base partial dentures.

(iv) Any type of permanent soft reline (e.g., molloplast).

(v) Precision attachments.

(((~~(iv)~~))) (vi) Replacement of replaceable parts for semi-precision or precision attachments.

(g) **Implant services.** The department does not cover:

(i) Any type of implant procedures, including, but not limited to, any tooth implant abutment (e.g., periosteal implant, eposteal implant, and transosteal implant), abutments or implant supported crown, abutment supported retainer, and implant supported retainer.

(ii) Any maintenance or repairs to procedures listed in (g)(i) of this subsection.

(iii) The removal of any implant as described in (g)(i) of this subsection.

(h) **Fixed prosthodontics.** The department does not cover:

(i) Any type of fixed partial denture pontic or fixed partial denture retainer.

(ii) Any type of precision attachment, stress breaker, connector bar, coping, cast post, or any other type of fixed attachment or prosthesis.

(i) **Oral and maxillofacial surgery.** The department does not cover:

(i) Any oral surgery service not listed in WAC 388-535-1094.

(ii) Any oral surgery service that is not listed in the department's list of covered current procedural terminology (CPT) codes published in the department's current rules or billing instructions.

(j) **Adjunctive general services.** The department does not cover:

(i) Anesthesia, including, but not limited to:

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

(C) Trigeminal division block anesthesia as a separate procedure.

(D) Medication for oral sedation, or therapeutic intramuscular (IM) drug injections, including antibiotic and injection of sedative.

(E) Application of any type of desensitizing medicament or resin.

(ii) Other general services including, but not limited to:

(A) Fabrication of an athletic mouthguard.

(B) Occlusion analysis.

(C) Occlusal adjustment, tooth or restoration adjustment or smoothing, or odontoplasties.

(D) Enamel microabrasion.

(E) Dental supplies such as toothbrushes, toothpaste, floss, and other take home items.

(F) Dentist's or dental hygienist's time writing or calling in prescriptions.

(G) Dentist's or dental hygienist's time consulting with clients on the phone.

(H) Educational supplies.

(I) Nonmedical equipment or supplies.

(J) Personal comfort items or services.

(K) Provider mileage or travel costs.

(L) Fees for no-show, cancelled, or late arrival appointments.

(M) Service charges of any type, including fees to create or copy charts.

(N) Office supplies used in conjunction with an office visit.

(O) Teeth whitening services or bleaching, or materials used in whitening or bleaching.

AMENDATORY SECTION (Amending WSR 03-19-080, filed 9/12/03, effective 10/13/03)

WAC 388-535-1350 Payment methodology for dental-related services. The ((~~medical assistance administration (MAA)~~)) department uses the description of dental services described in the American Dental Association's Current Dental Terminology, and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, ((~~MAA~~)) the department pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100 and 388-535-1400.

(2) ((~~MAA~~)) The department sets maximum allowable fees for dental services provided to ((~~children~~)) clients twenty years of age and younger as follows:

(a) ((~~MAA's~~)) The department's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) ((~~MAA~~)) The department consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) ((~~MAA~~)) The department consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) ((~~MAA~~)) The department reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(5) ((~~MAA~~)) The department pays eligible providers listed in WAC 388-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

(6) Dental hygienists who have a contract with ((~~MAA~~)) the department are paid at the same rate as dentists who have a contract with ((~~MAA~~)) the department, for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists who have a contract with ((~~MAA~~)) the department are paid at the same rate as dentists who have a contract with ((~~MAA~~)) the department, for providing dentures and partials.

(8) ((~~MAA~~)) The department makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) ((~~MAA~~)) The department may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(10) ((~~MAA~~)) The department does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in ((~~MAA's~~)) the department's reimbursement for comprehensive oral evaluations or limited oral evaluations.

AMENDATORY SECTION (Amending WSR 03-19-080, filed 9/12/03, effective 10/13/03)

WAC 388-535-1400 Payment for dental-related services. (1) The ((~~medical assistance administration (MAA)~~)) department considers that a provider who furnishes covered dental services to an eligible client has accepted ((~~MAA's~~)) the department's rules and fees.

(2) Participating providers must bill ((~~MAA~~)) the department their usual and customary fees.

(3) Payment for dental services is based on ((~~MAA's~~)) the department's schedule of maximum allowances. Fees listed in the ((~~MAA~~)) department's fee schedule are the maximum allowable fees.

(4) ((~~MAA~~)) The department pays the provider the lesser of the billed charge (usual and customary fee) or ((~~MAA's~~)) the department's maximum allowable fee.

(5) ((~~MAA~~)) The department pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) Participating providers must bill a client according to WAC 388-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 388-535-1240 and 388-535-1290.

AMENDATORY SECTION (Amending WSR 03-19-080, filed 9/12/03, effective 10/13/03)

WAC 388-535-1450 Payment for denture laboratory services. This section applies to payment for denture laboratory services provided to eligible clients twenty years of age and younger. The ((~~medical assistance administration~~

~~(MAA)~~)) department does not directly reimburse denture laboratories. ((~~MAA's~~)) The department's reimbursement for complete dentures, ((~~immediate dentures,~~)) partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

AMENDATORY SECTION (Amending WSR 02-13-074, filed 6/14/02, effective 7/15/02)

WAC 388-535-1500 Payment for dental-related hospital services. This section applies to payment for dental-related hospital services provided to eligible clients twenty years of age and younger. The ((~~medical assistance administration (MAA)~~)) department pays for medically necessary dental-related hospital inpatient and outpatient services in accord with WAC 388-550-1100.

AMENDATORY SECTION (Amending WSR 08-08-064, filed 3/31/08, effective 5/1/08)

WAC 388-535-1550 Payment for dental care provided out-of-state. This section applies to payment for dental care provided out-of-state to eligible clients twenty years of age and younger. See WAC 388-501-0180, 388-501-0182, and 388-501-0184 for services provided outside the state of Washington. See WAC 388-501-0175 for designated bordering cities.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-535-1247	Dental-related services for clients age twenty-one and older—General.
WAC 388-535-1255	Covered dental-related services—Adults.
WAC 388-535-1257	Covered dental-related services for clients age twenty-one and older—Preventive services.
WAC 388-535-1259	Covered dental-related services for clients age twenty-one and older—Restorative services.
WAC 388-535-1261	Covered dental-related services for clients age twenty-one and older—Endodontic services.
WAC 388-535-1263	Covered dental-related services for clients age twenty-one and older—Periodontic services.
WAC 388-535-1266	Covered dental-related services for clients age twenty-one and older—Prosthodontics (removable).
WAC 388-535-1267	Covered dental-related services for clients age twenty-one and older—Oral and maxillofacial surgery services.
WAC 388-535-1269	Covered dental-related services for clients age twenty-one and older—Adjunctive general services.
WAC 388-535-1271	Dental-related services not covered for clients age twenty-one and older.
WAC 388-535-1280	Obtaining prior authorization for dental-related services for clients age twenty-one and older.

WSR 11-03-003
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-03—Filed January 5, 2011, 3:06 p.m., effective January 5, 2011, 3:06 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000Z and 220-52-04600D; and amending WAC 220-52-040 and 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047, 77.04.020, and 77.70.430.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Mandatory meat pick-out rate allowance for coastal crab will be achieved by the opening dates contained herein. The special management areas are listed in accordance with state/tribal management agreements. The stepped opening periods/areas will also provide for fair start provisions. There is insufficient time to adopt permanent rules.

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 2, Amended 0, Repealed 2.

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: January 5, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-52-04000C Commercial crab fishery. Lawful and unlawful gear, methods and other unlawful acts. (1) Notwithstanding the provisions of WAC 220-52-040, effective immediately until further notice, it is unlawful for any fisher or wholesale dealer or buyer to land or purchase Dungeness crab taken from Grays Harbor, Willapa Bay, the Columbia River, or Washington coastal or adjacent waters of the Pacific Ocean through January 31, 2011, from any vessel unless:

(a) A valid Washington crab vessel inspection certificate has been issued to the delivering vessel.

(b) Vessel hold inspection certificates dated from November 30, 2010, to January 13, 2011 are only valid for the area south of 46°28.00.

(c) The vessel inspection certificate numbers are recorded on all shellfish tickets completed for coastal Dungeness crab landings through January 31, 2011.

(2) Notwithstanding the provisions of WAC 220-52-040, it is permissible for a vessel not designated on a Dungeness crab coastal fishery license to transport or deploy up to 250 pots at any one time for deployment in the coastal crab fishery between Klipsan Beach (46°28.00) and the U.S./Canada Border. The primary operator of the vessel associated with the pots being transported must be aboard the vessel while the pots are being deployed. All other provisions of the permanent rule remain in effect.

(a) Such a vessel may deploy crab gear for a 40-hour period immediately preceding the season opening date and during the 48-hour period immediately following the season opening date.

NEW SECTION

WAC 220-52-04600F Coastal crab seasons. Notwithstanding the provisions of WAC 220-52-046, effective immediately until further notice, it is unlawful to fish for Dungeness crab in Washington coastal waters, the Pacific Ocean, Grays Harbor, Willapa Bay, or the Columbia River, except as provided for in this section.

(1) The area from Klipsan Beach (46°28.00) to the WA/OR border (46°15.00) and Willapa Bay: Open.

(2) For the purposes of this order, the waters of Willapa Bay are defined to include the marine waters east of a line connecting 46°44.76 N, 124°05.76 W and 46°38.93 N, 124°04.33 W.

(3) Dungeness crab license holders, or any vessel or vessel operator designated on the license that participated in the coastal commercial Dungeness crab fishery in the waters from Point Arena, California, to Klipsan Beach, Washington (46°28.00), including Willapa Bay, before the area north of Klipsan Beach (46°28.00) opens, are prohibited from:

a. Fishing in the area between Klipsan Beach (46°28.00) and Oysterville (46°33.00) until 8:00 A.M., January 25, 2011.

b. Fishing in the area between Oysterville (46°33.00) and the U.S./Canada border until 8:00 A.M., February 19, 2011.

(4) Crab gear may be set in the area between Klipsan Beach (46°28.00) and the U.S./Canada Border, including Grays Harbor, beginning at 8:00 a.m. January 13, 2011.

(5) It is permissible to pull crab gear in the area between Klipsan Beach and the U.S./Canada Border, including Grays Harbor, beginning at 12:01 a.m. January 15, 2011.

(6) The Quinault primary special management area (PSMA) is closed to fishing for Dungeness crab until further notice. The PSMA includes the area shoreward of a line approximating the 27-fathom depth curve between Raft River (47º28.00) and Copalis River (47°08.00) according to the following coordinates:

Northeast Corner (Raft River):	47°28.00 N. Lat.	124°20.70 W. Lon.
Northwest Corner:	47°28.00 N. Lat.	124°34.00 W. Lon.
Southwest Corner:	47°08.00 N. Lat.	124°25.50 W. Lon.
Southeast Corner (Copalis River):	47°08.00 N. Lat.	124°11.20 W. Lon.

(7) The Quileute special management area (SMA) is closed to fishing for Dungeness crab until further notice. The SMA includes the area shoreward of a line approximating the 30-fathom depth curve between Destruction Island and Cape Johnson according to the following points:

• Northeast Corner (Cape Johnson):	47°58.00' N. Lat.	124°40.40' W. Lon.
• Northwest Corner:	47°58.00' N. Lat.	124°49.00' W. Lon.
• Southwest Corner:	47°40.50' N. Lat.	124°40.00' W. Lon.
• Southeast Corner (Destruction Island):	47°40.50' N. Lat.	124°24.43' W. Lon.

(8) The Makah special management area (SMA) is closed to fishing until further notice. The SMA includes the waters between 48°02.15 N. Lat. and 48°19.50 N. Lat. east of a line connecting those points and approximating the 25-fathom line according to the following coordinates:

• Northeast Corner (Tatoosh Island)		
• Northwest Corner:	48°19.50 N. Lat.	124°50.45 W. Lon.
• Southwest Corner:	48°02.15 N. Lat.	124°50.45 W. Lon.
• Southeast Corner:	48°02.15 N. Lat.	124°41.00 W. Lon.

(9) All other provisions of the permanent rule remain in effect.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 220-52-04000Z	Commercial crab fishery. Lawful and unlawful gear, methods and other unlawful acts. (10-311)
WAC 220-52-04600D	Coastal crab seasons (10-325)

WSR 11-03-018
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed January 7, 2011, 2:55 p.m., effective February 1, 2011]

Effective Date of Rule: February 1, 2011.

Purpose: The department is proposing to amend by emergency adoption WAC 388-478-0020 Payment standards for TANF, SFA and RCA, 388-478-0035 Maximum earned income limits for TANF, SFA and RCA, and 388-436-0050 Determining financial need and benefit amount for CEAP.

The department is reducing by fifteen percent:

- TANF, SFA, RCA, CEAP payment standards;
- The maximum gross earned income limit; and
- The grant maximum payment (from $1,107 to $941).

These changes are necessary in response to address a growing WorkFirst budget shortfall, driven by increased demand for services by families affected by the economic recession as described [in] "WorkFirst reductions" announcement dated December 17, 2010.

Citation of Existing Rules Affected by this Order: Amending WAC 388-478-0020, 388-478-0035, and 388-436-0050.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.660, and 74.08.090.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The department needs to make further reductions to TANF-related programs in order to achieve a balanced WorkFirst budget for the current fiscal year (which ends June 30, 2011) and the 2011-13 biennium (which begins July 1, 2011). This shortfall is the result of increased demand for TANF benefits due to the economic recession. In the last two years, the WorkFirst caseload has grown by more than thirty percent, from 51,106 cases in July 2008 to 66,634 cases in June of this year.

In September 2010, the governor directed agencies to implement cuts by October 1 to avoid running out of state general funds to address a growing WorkFirst budget shortfall. In particular, the Governor's Executive Order 10-04 (Ordering Expenditure Reductions in Allotments of State General Fund Appropriations), signed on September 13, 2010, found that:

- Revenues have fallen short of projections;
- The current official state economic and revenue forecast of general fund revenues is less than the official estimate upon which the state's 2009-2011 biennial operating budget and supplemental operating budget were enacted; and
- The anticipated revenues combined with the beginning cash balance of the general fund are insufficient to meet anticipated expenditures from this fund for the remainder of the current fiscal period.

Accordingly, the governor ordered across-the-board reductions of state general fund allotments by 6.287%, effective October 1, 2010.

In November 2010, the departments announced further reductions to keep the WorkFirst budget in balanced [balance]. The projected WorkFirst deficit reached approximately $82 million for current fiscal year and $225 million for the next biennium.

In December 2010:

- During December 11, 2010, special session, HB 3225 approved by [the] legislature modified appropriations for the 2009-11 operating budget. The state general fund appropriations were reduced by $490.4 million, while the total budgeted amount was reduced by $336.5 million. The department appropriations included a reduction of $856,000 GF-S for the remaining of SFY 2011.
- December 15, 2010, Governor Gregoire announced proposed 2011-2013 budget cuts needed to close an additional $4.6 billion projected shortfall in the next state fiscal biennium, and proposed eliminating or restructuring many state programs, agencies, boards and commissions. "We face unprecedented times," the governor said. "Few alive today have witnessed a recession of this magnitude and length." See the governor's proposed budget for SFY 2011-2013 at this link http://www.governor.wa.gov/priorities/budget/press_packet.pdf.

The timing of the proposed budget reductions will lessen the adverse impact on families. If immediate budget reductions are not realized, the department will have to make additional cuts in the future to TANF/WorkFirst assistance programs to stay within budget. Additional cuts could include greater reduction in services than those currently proposed, and/or eliminating benefits rather than reducing them. These reductions would have a much greater detrimental effect on vulnerable families with children in need.

The department is concurrently working on the permanent rule-making process.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, 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 3, Repealed 0.

Date Adopted: January 7, 2011.

Craig Lowe, Manager
Rules and Policies Assistance Unit

Assistance Unit Members	Net Income Limit
1	$ ((~~323~~)) 275
2	((~~407~~)) 346
3	((~~505~~)) 429
4	((~~594~~)) 505
5	((~~685~~)) 582
6	((~~779~~)) 662
7	((~~900~~)) 762
8 or more	((~~996~~)) 847

AMENDATORY SECTION (Amending WSR 09-14-040, filed 6/24/09, effective 7/25/09)

WAC 388-436-0050 Determining financial need and benefit amount for CEAP. (1) To be eligible for CEAP assistance, the assistance unit's nonexcluded income, minus allowable deductions, must be less than ninety percent of the TANF payment standard for households with shelter costs. The net income limit for CEAP assistance units is:

(2) The assistance unit's allowable amount of need is the lesser of:

(a) The TANF payment standard, based on assistance unit size, for households with shelter costs as specified under WAC 388-478-0020; or

(b) The assistance unit's actual emergent need, not to exceed maximum allowable amounts, for the following items:

Need Item: Maximum allowable amount by assistance unit size:

	1	2	3	4	5	6	7	8 or more
Food	$((~~217~~)) 184	$((~~276~~)) 235	$((~~341~~)) 290	$((~~402~~)) 342	$((~~463~~)) 394	$((~~526~~)) 447	$((~~600~~)) 510	$((~~664~~)) 564
Shelter	((~~265~~)) 225	((~~334~~)) 284	((~~416~~)) 354	((~~490~~)) 417	((~~564~~)) 479	((~~639~~)) 543	((~~740~~)) 629	((~~818~~)) 695
Clothing	((~~31~~)) 26	((~~39~~)) 33	((~~48~~)) 41	((~~57~~)) 48	((~~65~~)) 55	((~~75~~)) 64	((~~85~~)) 72	((~~96~~)) 82
Minor Medical Care	((~~184~~)) 156	((~~234~~)) 199	((~~290~~)) 247	((~~341~~)) 290	((~~393~~)) 334	((~~444~~)) 377	((~~516~~)) 439	((~~570~~)) 485
Utilities	((~~89~~)) 76	((~~113~~)) 96	((~~140~~)) 119	((~~164~~)) 139	((~~189~~)) 161	((~~216~~)) 184	((~~250~~)) 213	((~~276~~)) 235
Household maintenance	((~~65~~)) 55	((~~83~~)) 71	((~~103~~)) 88	((~~121~~)) 103	((~~140~~)) 119	((~~159~~)) 135	((~~183~~)) 156	((~~202~~)) 172
Job related transportation	((~~359~~)) 305	((~~453~~)) 385	((~~562~~)) 478	((~~661~~)) 562	((~~762~~)) 648	((~~866~~)) 736	((~~1000~~)) 850	((~~1107~~)) 941
Child related transportation	((~~359~~)) 305	((~~453~~)) 385	((~~562~~)) 478	((~~661~~)) 562	((~~762~~)) 648	((~~866~~)) 736	((~~1000~~)) 850	((~~1107~~)) 941

(3) The assistance unit's CEAP payment is determined by computing the difference between the allowable amount of need, as determined under subsection (2) of this section, and the total of:

(a) The assistance unit's net income, as determined under subsection (1) of this section;

(b) Cash on hand, if not already counted as income; and

(c) The value of other nonexcluded resources available to the assistance unit.

(4) The assistance unit is not eligible for CEAP if the amount of income and resources, as determined in subsection (3) of this section, is equal to or exceeds its allowable amount of need.

AMENDATORY SECTION (Amending WSR 08-16-105, filed 8/5/08, effective 9/5/08)

WAC 388-478-0020 Payment standards for TANF, SFA, and RCA. (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$((~~359~~)) 305	6	$((~~866~~)) 736
2	((~~453~~)) 385	7	((~~1,000~~)) 850
3	((~~562~~)) 478	8	((~~1,107~~)) 941
4	((~~661~~)) 562	9	((~~1,215~~)) 1,033
5	((~~762~~)) 648	10 or more	((~~1,321~~)) 1,123

(2) The payment standards for TANF, SFA, and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	$((~~218~~)) 185	6	$((~~526~~)) 447
2	((~~276~~)) 235	7	((~~608~~)) 517
3	((~~341~~)) 290	8	((~~673~~)) 572
4	((~~402~~)) 342	9	((~~739~~)) 628
5	((~~464~~)) 394	10 or more	((~~803~~)) 683

AMENDATORY SECTION (Amending WSR 08-16-105, filed 8/5/08, effective 9/5/08)

WAC 388-478-0035 Maximum earned income limits for TANF, SFA and RCA. To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	$((~~718~~)) 610	6	$((~~1,732~~)) 1,472
2	((~~906~~)) 770	7	((~~2,000~~)) 1,700
3	((~~1,124~~)) 955	8	((~~2,214~~)) 1,882
4	((~~1,322~~)) 1,124	9	((~~2,430~~)) 2,066
5	((~~1,524~~)) 1,295	10 or more	((~~2,642~~)) 2,246

WSR 11-03-019
EMERGENCY RULES
DEPARTMENT OF HEALTH
(Board of Pharmacy)

[Filed January 7, 2011, 3:19 p.m., effective January 7, 2011, 3:19 p.m.]

Effective Date of Rule: Immediately.

Purpose: WAC 246-887-100, the rule adds the chemicals JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol to Schedule I. Schedule I substances have a high potential for abuse and no accepted medical use. The rule makes it illegal to sell or possess these chemicals or products containing these substances. It gives clear authority to law enforcement to prosecute for the sale and possession and protects the public by alerting them to the potential health risk.

Citation of Existing Rules Affected by this Order: Amending WAC 246-887-100.

Statutory Authority for Adoption: RCW 69.50.201, 69.50.203.

Other Authority: RCW 18.64.005(7).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: By adding the synthetic cannabinoid chemicals to Scheulde [Schedule] I of the controlled substances list, the board of pharmacy identifies these substances as having a high potential for abuse with no medical use. The rule gives law enforcement clear authority to prosecute for the sale and possession of these substances and is consistent with the federal Drug Enforcement Administration's proposed rule.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, 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: January 7, 2011.

Gary G. Harris
Board Chair

AMENDATORY SECTION (Amending WSR 01-03-108, filed 1/22/01, effective 1/22/01)

WAC 246-887-100 Schedule I. The board finds that the following substances have high potential for abuse and have no accepted medical use in treatment in the United States or that they lack accepted safety for use in treatment under medical supervision. The board, therefore, places each of the following substances in Schedule I.

(a) The controlled substances listed in this section, by whatever official name, common or usual name, chemical name, or brand name, are included in Schedule I.

(b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Acetyl-alpha-methylfentanyl (N-[1-(1-methyl-2-phenethyl)-4-piperidinyl]-N-phenylacetamide);

(2) Acetylmethadol;

(3) Allylprodine;

(4) Alphacetylmethadol; ((~~[(except for levo-alphacetylmethadol - also known as levo-alpha-acetylmethadol, levomethadyl acetate or LAAM);]~~)) (except for levo-alphacetylmethadol - also known as levo-alpha-acetylmethadol, levomethadyl acetate or LAAM);

(5) Alphameprodine;

(6) Alphamethadol;

(7) Alpha-methylfentanyl (N-[1-alpha-methyl-beta-phenyl) ethyl-4-piperidyl] propionanilide; 1-(1-methyl-2-phenylethyl)-4-(N-propanilido) piperidine);

(8) Benzethidine;

(9) Betacetylmethadol;

(10) Betameprodine;

(11) Betamethadol;

(12) Betaprodine;

(13) Clonitazene;

(14) Dextromoramide;

(15) Diampromide;

(16) Diethylthiambutene;

(17) Difenoxin;

(18) Dimenoxadol;

(19) Dimepheptanol;

(20) Dimethylthiambutene;

(21) Dioxaphetyl butyrate;

(22) Dipipanone;

(23) Ethylmethylthiambutene;

(24) Etonitazene;

(25) Etoxeridine;

(26) Furethidine;

(27) Gamma-hydroxybutyric Acid (other names include: GHB);

(28) Hydroxypethidine;

(29) Ketobemidone;

(30) Levomoramide;

(31) Levophenacylmorphan;

(32) 3-Methylfentanyl (N-[3-Methyl-1-(2-phenylethyl)-4-piperidyl)]-N-phenylpropanamide);

(33) Morpheridine;

(34) MPPP (1-Methyl-4-phenyl-4-propionoxypiperidine);

(35) Noracymethadol;

(36) Norlevorphanol;

(37) Normethadone;

(38) Norpipanone;

(39) PEPAP (1-(-2-phenethyl)-4-phenyl-4-acetoxypiperidine);

(40) Phenadoxone;

(41) Phenampromide;

(42) Phenomorphan;

(43) Phenoperidine;

(44) Piritramide;

(45) Proheptazine;

(46) Properidine;

(47) Propiram;

(48) Racemoramide;

(49) Tilidine;

(50) Trimeperidine.

(c) Opium derivatives. Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine;

(2) Acetyldihydrocodeine;

(3) Benzylmorphine;

(4) Codeine methylbromide;

(5) Codeine-N-Oxide;

(6) Cyprenorphine;

(7) Desomorphine;

(8) Dihydromorphine;

(9) Drotebanol;

(10) Etorphine (except hydrochloride salt);

(11) Heroin;

(12) Hydromorphinol;

(13) Methyldesorphine;

(14) Methyldihydromorphine;

(15) Morphine methylbromide;

(16) Morphine methylsulfonate;

(17) Morphine-N-Oxide;

(18) Myrophine;

(19) Nicocodeine;

(20) Nicomorphine;

(21) Normorphine;

(22) Pholcodine;

(23) Thebacon.

(d) Hallucinogenic substances. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quan-

tity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of paragraph (d) of this section, only, the term "isomer" includes the optical, position, and geometric isomers):

(1) 4-bromo-2,5-dimethoxy-amphetamine: Some trade or other names: 4-bromo-2,5-dimethoxy-a-methylphenethylamine; 4-bromo-2,5-DMA;

(2) 2,5-dimethoxyamphetamine: Some trade or other names: 2,5-dimethoxy-a-methylphenethylamine; 2,5-DMA;

(3) 2,5-dimethoxy-4-ethylamphetamine (DOET)

(4) 4-methoxyamphetamine: Some trade or other names: 4-methoxy-a-methylphenethylamine; paramethoxyamphetamine, PMA;

(5) 5-methoxy-3,4-methylenedioxy-amphetamine;

(6) 4-methyl-2,5-dimethoxy-amphetamine: Some trade and other names: 4-methyl-2,5-dimethoxy-a-methylphenethylamine; "DOM"; and "STP";

(7) 3,4-methylenedioxy amphetamine;

(8) 3,4-methylenedioxymethamphetamine (MDMA);

(9) 3,4,5-trimethoxy amphetamine;

(10) Bufotenine: Some trade or other names: 3-(beta-Dimethylaminoethyl)-5-hydroxindole; 3-(2-dimethylaminoethyl)-5-indolol; N, N-dimethylserotonin; 5-hydroxy-N,N-dimethyltryptamine; mappine;

(11) Diethyltryptamine: Some trade or other names: N,N-Diethyltryptamine; DET;

(12) Dimethyltryptamine: Some trade or other names: DMT;

(13) Ibogaine: Some trade or other names: 7-Ethyl-6,6 beta,7,8,9,10,12,13,-octahydro-2-methoxy-6,9methano-5H-pyndo (1',2':1,2) azepino (5,4-b) indole; Tabernanthe iboga;

(14) Lysergic acid diethylamide;

(15) Marihuana;

(16) Mescaline;

(17) Parahexyl-7374; some trade or other names: 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenzo[b,d]pyran; synhexyl;

(18) Peyote, meaning all parts of the plant presently classified botanically as Lophophora Williamsii Lemaire, whether growing or not, the seeds thereof, any extract from any part of such plant, and every compound, manufacture, salts, derivative, mixture, or preparation of such plant, its seeds, or extracts; (interprets 21 USC § 812(c), Schedule I (c)(12))

(19) N-ethyl-3-piperidyl benzilate;

(20) N-methyl-3-piperidyl benzilate;

(21) Psilocybin;

(22) Psilocyn;

(23) Tetrahydrocannabinols, synthetic equivalents of the substances contained in the plant, or in the resinous extractives of Cannabis, sp., and/or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as the following:

(i) Delta 1 - cis - or transtetrahydrocannabinol, and their optical isomers, excluding tetrahydrocannabinol in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration;

(ii) Delta 6 - cis - or transtetrahydrocannabinol, and their optical isomers;

(iii) Delta 3,4 - cis - or transtetrahydrocannabinol, and its optical isomers;

(iv) 5-(1,1-Dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol- 7297 (Other names: CP-47,497);

(v) 5-(1,1-Dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol- 7298 (Other names: Cannabicyclohexanol and CP-47,497 C8 homologue);

(vi) 1-Butyl-3-(1-naphthoyl)indole-7173 (Other names: JWH-073);

(vii) 1-[2-(4-Morpholinyl)ethyl]-3-(1-naphthoyl)indole-7200 (Other names: JWH-200);

(viii) 1-Pentyl-3-(1-naphthoyl)indole-7118 (Other names: JWH-018 and AM678).

(Since nomenclature of these substances is not internationally standardized, compounds of these structures, regardless of numerical designation of atomic positions covered.)

(24) Ethylamine analog of phencyclidine: Some trade or other names: N-ethyl-1-phenylcyclohexylamine, (1-phenylcyclohexyl) ethylamine, N-(1-phenylcyclohexyl)ethylamine, cyclohexamine, PCE;

(25) Pyrrolidine analog of phencyclidine: Some trade or other names: 1-(1-phencyclohexyl)pyrrolidine; PCPy; PHP;

(26) Thiophene analog of phencyclidine: Some trade or other names: 1-(1-[2-thenyl]-cyclohexly)-pipendine; 2-thienylanalog of phencyclidine; TPCP; TCP;

(e) Depressants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(i) Mecloqualone;

(ii) Methaqualone.

(f) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers:

(i) Cathinone (also known as 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone and norephedrone)

(ii) Fenethylline;

(iii) N-ethylamphetamine;

(iv) 4-methylaminorex;

(v) N,N-dimethylamphetamine.

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.

WSR 11-03-032
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-04—Filed January 11, 2011, 1:43 p.m., effective January 16, 2011]

Effective Date of Rule: January 16, 2011.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Emergency closure is needed to reduce incidental mortality of wild steelhead. The 2010-2011 forecast of wild steelhead returning to the Green River is only three hundred sixty-four fish, well below the spawning goal of two thousand steelhead. This closure will reduce the incidental hooking mortalities of wild steelhead. There is insufficient time to adopt permanent rules.

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 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: January 11, 2011.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900M Exceptions to statewide rules—Green River (King Co.) Notwithstanding the provisions of WAC 232-28-619:

(1) Effective January 16, 2011, until further notice, it is unlawful to fish for game fish in waters of the Green River from the 1st Ave. South Bridge in Seattle upstream to the South 277th Bridge in Auburn.

(2) Effective February 1, 2011, until further notice, it is unlawful to fish for game fish in waters of the Green River from the 277th Bridge in Auburn upstream to the Tacoma Headworks Dam.

WSR 11-03-033
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-05—Filed January 11, 2011, 1:44 p.m., effective January 16, 2011]

Effective Date of Rule: January 16, 2011.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The 2010-2011 forecast of wild steelhead returning to the Puyallup River basin is well below the spawning goal. This closure will reduce the incidental hooking mortalities of wild steelhead. Puget Sound wild steelhead populations are listed as "threatened" under the Endangered Species Act. There is insufficient time to adopt permanent rules.

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 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: January 11, 2011.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900N Exceptions to statewide rules—White, Carbon and Puyallup rivers. Notwithstanding the provisions of WAC 232-28-619:

(1) Effective January 16, 2011, until further notice, it is unlawful to fish in those waters of the White River from the mouth to the R Street Bridge in Auburn.

(2) Effective January 16, 2011, until further notice, it is unlawful to fish in those waters of the Carbon River from the mouth to the Highway 162 Bridge in Auburn.

(3) Effective January 16, 2011, until further notice, it is unlawful to fish in those waters of the Puyallup River from the mouth of Carbon River upstream.

WSR 11-03-038
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed January 12, 2011, 9:52 a.m., effective January 12, 2011, 9:52 a.m.]

Effective Date of Rule: Immediately.

Purpose: The department is amending chapter 388-71 WAC, Home and community services and programs; and chapter 388-106 WAC, Long-term care services. Amendments are necessary to implement adult day health (ADH) changes required by federal directive, which requires the program to be offered under a different federal statutory authority - 1915(i) of the Social Security Act. The 1915(i) option has different financial eligibility requirements than the current program. ADH transportation will no longer be provided by the medicaid transportation broker. Transportation will be the responsibility of the ADH center to provide or arrange.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-71-0734; and amending WAC 388-71-0720, 388-71-0724, 388-71-0726, and 388-106-0815.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Other Authority: Section 1915(i) of the Social Security Act.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: All modifications are required to comply with the new federally-approved 1915(i) plan for the provision of adult day health services. Federal funds for this program ended December 31, 2009, due to a federal directive requiring ADH services to be removed from the rehabilitative services section of the medicaid state plan. In order to continue ADH services, the aging and disability services administration (ADSA) will provide ADH services under Section 1915(i) of the Social Security Act. The 1915(i) option has different financial eligibility rules that require nonexcluded income to be at or below one hundred fifty percent of the federal poverty level (FPL). ADSA will no longer pay for transportation to ADH by the medicaid transportation broker. ADSA will increase the ADH rate and ADH providers can provide transportation directly or through an arrangement with a third party. The department is currently in the process of filing the CR-102, proposed rule making. This CR-103E continues emergency rules while the department completes the process for permanent adoption.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 1, Amended 4, Repealed 1; 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 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 1, Amended 4, Repealed 1.

Date Adopted: January 10, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-71-0720 Adult day health—Assessment and service plan. (1) The department or an authorized case manager must perform a CARE assessment to determine a client's need for a referral to adult day health, per WAC 388-106-0065. Based on the assessment, the case manager determines whether the client should be referred for day health services or whether the client's needs can be met in other ways.

(2) If the client **has** a department or area agency on aging case manager, the adult day health center or other referral source must notify the case manager of the client's potential adult day health service need. The case manager must ((~~assess~~)) determine the client's need for a referral to ADH skilled nursing or skilled rehabilitative therapy within the department's normal time frames for client reassessments.

(3) If the client does not have a department or area agency on aging case manager, the adult day health center or other referral source must notify the department of the referral and the client's potential adult day health service need, or refer the client to the department for intake. The department's assigned case manager must assess the client's need for a referral to adult day health services within the department's normal time frames for initial client eligibility assessments.

(4) The case manager may consult with the client's practitioner, department or area agency on aging nursing services staff, or other pertinent collateral contacts, concerning the client's need for a referral to ADH skilled nursing or rehabilitative therapy.

(5) If the department or area agency on aging case manager determines ((~~and documents a potential unmet~~)) a need for ((~~day health services~~)) a referral to skilled nursing or skilled rehabilitative therapy, the case manager works with the client and/or the client's representative to develop a service plan that documents the potential unmet needs and ((~~the anticipated number of days per week that the services are needed~~)) whether the client wants a referral to ADH or another service provider.

(6) The case manager refers the client to a department contracted day health center for evaluation and the development of a preliminary negotiated plan of care.

((~~(6)~~)) (7) The department or area agency on aging case manager must reassess adult day health clients at least annually. Clients must also be reassessed if they have a break in service of more than thirty days. The adult day center must inform the case manager of the break in service so payment authorization can be discontinued.

((~~(7)~~)) (8) Recipients of adult day health services must be assessed by the department or an authorized case manager for continued or initial eligibility as follows:

(a) Annual reassessment for department clients;

(b) Adult day health quarterly review for current nondepartmental clients as resources allow; and

(c) New referrals for adult day health services are to be forwarded to local department offices for intake and assessment for eligibility.

(((~~(8)~~))) (9) The department or area agency on aging case manager must review a client's continued eligibility for adult day health services every ninety days, coinciding with the quarterly review completed by the adult day health program. At the case manager's discretion, additional information will be gathered through face to face, collateral or other contact methods to determine continued eligibility. Services will be continued, adjusted, or terminated based upon the case manager's determination during the eligibility review.

AMENDATORY SECTION (Amending WSR 03-06-024, filed 2/24/03, effective 7/1/03)

WAC 388-71-0724 Adult day services—Contracting and rates. (1) The department, or an area agency on aging (or other department designee) as authorized by the department, must determine that the adult day care or day health center meets the applicable adult day care or day health requirements and any additional requirements for contracting with the area agency on aging through a COPES contract or with the department through a medicaid provider contract. If a center is contracting for both day care and day health, requirements of both adult day services must be met.

(a) A prospective provider desiring to provide adult day services shall be provided an application form from the department or the area agency on aging.

(b) The prospective provider will provide the area agency on aging with evidence of compliance with, or administrative procedures to comply with, the adult day service rules under this chapter.

(c) The area agency on aging will conduct a site inspection of the adult day center and review of the requirements for contracting.

(d) Within thirty days of completing the site visit, the area agency on aging will advise the prospective provider in writing of any deficiencies in meeting contracting requirements.

(e) The area agency on aging will verify correction of any deficiencies within thirty days of receiving notice from the prospective provider that deficiencies have been corrected, before contracting can take place.

(f) The area agency on aging will provide the department with a written recommendation as to whether or not the center meets contracting requirements.

(2) Minimum application information required to apply for contract with the department, or an area agency on aging includes:

(a) Mission statement, articles of incorporation, and bylaws, as applicable;

(b) Names and addresses of the center's owners, officers, and directors as applicable;

(c) Organizational chart;

(d) Total program operating budget including all anticipated revenue sources and any fees generated;

(e) Program policies and operating procedure manual;

(f) Personnel policies and job descriptions of each paid staff position and volunteer position functioning as staff;

(g) Policies and procedures meeting the requirements of mandatory reporting procedures as described in chapter 74.34 RCW to adult protective services for vulnerable adults and local law enforcement for other participants;

(h) Audited financial statement;

(i) Floor plan of the facility;

(j) Local building inspection, fire department, and health department reports;

(k) Updated TB test for each staff member according to local public health requirements;

(l) Sample client case file including all forms that will be used; and

(m) Activities calendar for the month prior to application, or a sample calendar if the day service provider is new.

(3) The area agency on aging or other department designee monitors the adult day center at least annually to determine continued compliance with adult day care and/or adult day health requirements and the requirements for contracting with the department or the area agency on aging.

(a) The area agency on aging will send a written notice to the provider indicating either compliance with contacting requirements or any deficiencies based on the annual monitoring visit and request a corrective action plan. The area agency on aging will determine the date by which the corrective action must be completed

(b) The area agency on aging will notify the department of the adult day center's compliance with contracting requirements or corrected deficiencies and approval of the corrective action plan for continued contracting.

(4) Adult day care services are reimbursed on an hourly basis up to four hours per day. Service provided four or more hours per day will be reimbursed at the daily rate.

(5) ((~~Payment rates are established on an hourly and daily basis for adult day care centers as may be adopted in rule.~~)) Rate adjustments are determined by the state legislature. ((~~Providers seeking current reimbursement rates can refer to SSPS billing instructions~~)) Information on current reimbursement rates is available at http://www.adsa.dshs.wa.gov/professional/ under the "office of rates management" section.

(6) ((~~Rates as of July 1, 2002, are as follows:~~))

((~~Counties~~	~~COPES Adult Day Care~~	
	~~Daily Rate~~	~~Hourly Rate~~
~~King~~	~~$36.48~~	~~$9.10~~
~~Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima~~	~~$32.45~~	~~$8.11~~
~~All other counties~~	~~$30.75~~	~~$7.69~~))

(((~~(7)~~))) Payment rates are established on a daily basis for adult day health centers ((~~as may be adopted in rule~~)). Rate adjustments are determined by the state legislature. ((~~Providers seeking~~)) Information on current reimbursement rates ((~~can refer to MAA billing instructions or http://maa.~~

~~dshs.wa.gov~~)) is available at http://www.adsa.dshs.wa.gov/professional/ under the "office of rates management" section.

(((~~(8)~~))) (7) ((~~Rates as of July 1, 2002, are as follows:~~))

((~~Counties~~	~~Day Health Daily~~
~~King~~	~~$47.48~~
~~Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima~~	~~$43.06~~
~~All other counties~~	~~$40.68~~))

A one-time only initial intake evaluation provided by an adult day health center, including development of a negotiated care plan, is reimbursed at an established rate ((~~as may be adopted in rule~~)). ((~~The rate as of July 1, 2002 is eighty-nine dollars and thirty-eight cents~~)) Information on current reimbursement rates is available at http://www.adsa.dshs.wa.gov/professional/ under the "office of rates management" section. Rate adjustments are determined by the state legislature. Separate reimbursement is not available for subsequent evaluations.

(((~~(9)~~))) (8) Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation providers or informal resources.

(((~~(10)~~))) (9) ((~~Transportation to and from the program site is not reimbursed under the adult day health rate. Transportation arrangements for eligible medicaid clients are made with local medicaid transportation brokers, informal providers, or other available resources per chapter 388-546 WAC~~)) Adult day health providers must arrange or provide transportation within the daily rate.

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 03-06-024, filed 2/24/03, effective 7/1/03)

WAC 388-71-0726 Adult day health transportation. ((~~The following rules apply if medicaid transportation services are requested:~~

~~(1) The day health center must refer the client to a local medicaid transportation broker. The broker may consult with the client, the client's physician, family, case manager, or day health center as needed in making any transportation arrangements.~~

~~(2) In referring the client to a day health center, the case manager may consider: The frailty and endurance of the client, the client's skilled nursing or rehabilitative therapy needs, and a reasonable round-trip travel time that may not exceed two hours, unless there is no closer center that can meet the client's skilled care needs. Documentation of language barriers may be considered on an exception to rule basis by the case manager.~~

~~(3) All brokered transportation under this subsection is subject to the requirements of chapter 388-546 WAC or its successors. In the case of any conflicts, the provisions of chapter 388-546 WAC take precedence~~)) (1) Adult day health providers must coordinate or provide transportation as necessary to assure client access to service.

(2) Adult day health providers must arrange or provide transportation within the daily rate.

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0815 Am I eligible for adult day health? (1) You are eligible for adult day health services if you meet all of the following criteria. You are:

(a) Age eighteen years or older.

(b) Enrolled in ((~~one of the following~~)) a categorically needy (CNP) medical assistance ((~~programs:~~

~~(i) Categorically needy (CNP);~~

~~(ii) Categorically needy qualified medicare beneficiaries (CNP-QMB);~~

~~(iii) General assistance - Expedited medicaid disability (GA-X); or~~

~~(iv) Alcohol and Drug Abuse Treatment and Support Act (ADATSA)~~)) program as defined in WAC 388-500-0005.

(c) Your nonexcluded income does not exceed one hundred fifty percent of the federal poverty level (FPL).

(d) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714((~~;~~)) and:

(i) There is a reasonable expectation that these services will improve, restore or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering; and

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and

(iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

(((~~(d)~~))) (e) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met.

(2) You are not eligible for adult day health if you:

(a) Can independently perform or obtain the services provided at an adult day health center;

(b) Have referred care needs that:

(i) Exceed the scope of authorized services that the adult day health center is able to provide;

(ii) Do not need to be provided or supervised by a licensed nurse or therapist;

(iii) Can be met in a less structured care setting; or

(iv) In the case of skilled care needs, are being met by paid or unpaid caregivers.

(c) Live in a nursing home or other institutional facility; or

(d) Are not capable of participating safely in a group care setting.

NEW SECTION

WAC 388-106-0820 Is there a wait list for adult day health? The department may maintain a wait list when the number of participants reaches federally approved capacity. Wait list clients will gain access in the following priority:

(1) Residents of nursing homes, or ICFs/MR, or hospital patients who are waiting for discharge will be ranked first on the wait list by date of application for services.

(2) All other applicants, in order of date and time the referral request is received by aging and disability services administration.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-71-0734	Limiting expenditures.

WSR 11-03-041
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2011-02—Filed January 13, 2011, 8:36 a.m., effective January 13, 2011, 8:36 a.m.]

Effective Date of Rule: Immediately.

Purpose: The rule establishes the requirements health carriers must follow for open enrollment periods and special enrollment periods resulting from a qualifying event for persons under age nineteen.

Statutory Authority for Adoption: RCW 48.02.060, 48.44.050, 48.46.200.

Other Authority: RCW 48.20.450; Pub. Law 111-148, sec. 2704 (2010).

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: Beginning September 23, 2010, the federal Patient Protection and Affordable Care Act requires that health carriers must not impose preexisting condition limitations on persons under age nineteen applying for health insurance as a condition of enrollment or the availability of coverage. In order to maintain the stability of the individual and small group health insurance markets in Washington, open enrollment periods are necessary to prevent adverse selection.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, 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 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 4, Amended 0, Repealed 0.

Date Adopted: January 13, 2011.

Mike Kreidler
Insurance Commissioner

SUBCHAPTER J

HEALTH PLAN ENROLLMENT AND COVERAGE REQUIREMENTS

NEW SECTION

WAC 284-43-1001 Purpose and scope. These rules explain the requirements in effect in Washington governing the issue of individual health insurance or health benefit plans to persons under age 19, based on Section 2704 of the Patient Protection and Affordable Care Act, P.L. 111-148 and the interim final regulations interpreting it, 45 C.F.R. 145.103 and 147.108, which provide that a carrier may not apply preexisting condition exclusions for persons under age nineteen.

NEW SECTION

WAC 284-43-1005 Definitions. As used in this section, unless the context requires otherwise:

(1) "Applicant" means a person who applies for enrollment in an individual health plan as a subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

(2) "Carrier" has the same meaning as its definition in RCW 48.43.005(18) and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act, P.L. 111-148.

(3) "Open enrollment" means a period of time as defined in these rules, held at the same time each year, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(4) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(5) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

NEW SECTION

WAC 284-43-1010 Preexisting conditions. For any individual health benefit plan, a carrier must waive any exclusion of benefits, including a denial of coverage, and may not otherwise limit coverage based upon a preexisting condition waiting period if the applicant or enrollee is a person under age 19. This requirement:

(1) Does not apply to an individual grandfathered plan under P.L. 111-148, the Patient Protection and Affordable Care Act;

(2) Includes those persons under age nineteen with a pre-existing condition who seek coverage as the primary insured or as a dependent or as a spouse under individual health benefit plans that permit the enrollment of dependents, and enrolled persons under age nineteen who seek benefits for which they are otherwise eligible.

NEW SECTION

WAC 284-43-1015 Enrollment of persons under age 19. (1) For any individual health benefit plan offered after January 1, 2011, the carrier must conduct an open enrollment period for persons under age nineteen during two time periods each year. The first open enrollment must occur from March 15 through April 30 of each year, and the second open enrollment period must occur from September 15 through October 31.

(2) A carrier must make a special enrollment period of not less than thirty-one days available to any person under age 19 who experiences a qualifying event. A qualifying event means the occurrence of one of the following:

(a) The person under age nineteen or the person under whose policy they were enrolled loses employer sponsored insurance;

(b) The person under age nineteen loses eligibility under medicaid or other public program providing health benefits;

(c) The person under age nineteen or the person under whose policy they were enrolled loses coverage as the result of dissolution of marriage;

(d) The person under age nineteen or the person under whose policy they were enrolled changes residence, and the health plan under which they were covered does not provide coverage in that person's new service area.

(e) The person for whom coverage is sought was born, placed for adoption or adopted within sixty days of the application for enrollment.

(3) During the enrollment periods described in subsection (1) and (2), or any other enrollment period, a carrier must not require a person under age nineteen applying for an individual health benefit plan to complete the standard health questionnaire designated under chapter 48.41 RCW or otherwise provide evidence of insurability.

(4) A carrier may offer enrollment in an individual health benefit plan outside the open or special enrollment period, but must not require any evidence of insurability or completion of the standard health questionnaire if the applicant is a person under age 19.

(5) Each carrier must prominently display on its website information about open enrollment periods and special enrollment periods for persons under age 19, and if the carrier elects to limit enrollment to the open and special enrollment periods, explain that fact on the website and provide contact information for the Washington State High Risk Pool and the Pre-existing Condition Insurance Pools.

WSR 11-03-046
EMERGENCY RULES
DEPARTMENT OF EARLY LEARNING

[Filed January 13, 2011, 2:43 p.m., effective January 13, 2011, 2:43 p.m.]

Effective Date of Rule: Immediately.

Purpose: The department of early learning (DEL) is amending working connections child care (WCCC) and seasonal child care (SCC) program rules in chapter 170-290 WAC. The rules:

1. Revise eligibility requirements for families to receive WCCC and SCC subsidy benefits as follows:

- Consumers who were receiving WCCC subsidy benefits in [on] January 1, 2011 (or apply for benefits in January 2011), must have countable income at or below one hundred seventy-five percent of the federal poverty guidelines (FPG), and may continue to be eligible as long as their countable monthly income remains at or below one hundred seventy-five percent of the FPG. This would be $2,671 per month for a family of three.
- Effective February 1, 2011, consumers initially applying for WCCC benefits, or reapplying after a termination of WCCC eligibility, must be determined eligible for temporary assistance for needy families (TANF) or be receiving a TANF grant to be eligible [for] WCCC. These consumers may remain eligible for WCCC until their countable income exceeds one hundred seventy-five percent of the FPG, even if the family is no longer eligible to receive TANF.

2. Effective February 1, 2011, raise child care copayments for certain WCCC consumers as follows:

- For consumers whose countable monthly income is above eighty-two percent of the FPG up to 137.5 percent of the FPG, copayments will increase from $50 to $60 per month; and
- For consumers whose countable monthly income is above 137.5 percent of the FPG through one hundred seventy-five percent of the FPG, monthly copayments will increase by amending the sliding scale formula as follows: The dollar amount equal to subtracting 137.5 percent of FPG from countable income, multiplying by forty-four percent, then adding $60 instead of $50.

Copayments for consumers with income at or below eighty-two percent of the FPG will remain at $15 per month.

3. Allow families on TANF to apply for SCC benefits. The current rules do not allow a family receiving TANF to also receive SCC. However, no new applications for SCC are being accepted at this time. The program has run out of funds for the current state fiscal year ending June 30, 2011.

These rules will replace emergency rules filed on December 17, 2010, filing number WSR 11-01-114, which are being rescinded. The replacement emergency rules clarify eligibility for consumers initially applying for WCCC benefits, or reapplying after a lapse in benefits. The previous emergency rules also limited WCCC eligibility to new appli-

cants who were receiving a TANF grant effective February 1. This rule extends WCCC eligibility both to consumers who are receiving TANF and those determined eligible for TANF.

The WCCC and SCC programs provide child care assistance to lower income parents who are working or attending approved school, training or other activities. More than 35,000 families in Washington state receive DEL child care subsidy assistance each month. For more information about these rules, please visit the DEL web site at http://www.del.wa.gov/laws/development/income.aspx.

Citation of Existing Rules Affected by this Order: Amending WAC 170-290-0005, 170-290-0075, 170-290-0085, 170-290-3520, and 170-290-3640.

Statutory Authority for Adoption: RCW 43.215.060 and 43.215.070.

Other Authority: Chapter 43.215 RCW.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Failure to implement WCCC and SCC spending cuts by emergency rule would result in these programs becoming oversubscribed and over budget, because of insufficient revenues to pay program benefits and higher than anticipated caseloads, causing the state to likely run out of funds for these programs before the end of the state fiscal year ending June 30, 2011 (SFY 2011). If that occurs, the state could be faced with terminating child care subsidies to all families in the WCCC and SCC programs, with serious disruptive effects to children, families, child care providers and the public welfare.

Washington state's economic situation continues to worsen. Current forecasts indicate that state tax revenues will be insufficient to meet appropriations in the 2010-2011 Supplemental Operating Budget Act ESSB 6444 (chapter 37, Laws of 2010 1st sp. sess.). Congress has not acted on extending American Reinvestment and Revitalization Act (ARRA) stimulus funding that the legislature had projected receiving to help balance the budget. See the 2010 Supplemental Omnibus Budget Overview - Operating Only.

In adopting ESSB 6444, the legislature anticipated that federal revenues in the WorkFirst "TANF (temporary assistance to needy families) Box" may fall short of estimates. WorkFirst is the state's "welfare-to-work" program, which includes DEL child care subsidy programs. As the economy declined and unemployment increased, in the last two years the state's WorkFirst caseload has grown by more than thirty percent, from 51,106 cases in July 2008 to 66,634 cases in June 2010. WorkFirst caseloads continue to rise.

By August 2010, Washington's WorkFirst program faced a projected $52 million budget shortfall in SFY 2011. DEL was directed to cut nearly $14.8 million in child care subsidy costs. This led the department to adopt the emergency rules filed in September, WSR 10-20-032.

By November 2010, the projected WorkFirst deficit had grown to more than $106 million. The governor directed WorkFirst agencies to further reduce spending by an additional $52 million to $54 million, including additional child care subsidy spending cuts. To help reach this target, DEL filed emergency rules in December 2010 ending WCCC and SCC subsidies for families with countable monthly income over one hundred seventy-five percent of the FPG on January 1, 2011, and revised eligibility requirements for families applying for WCCC or SCC on or after February 1, 2011.

Based on DEL's experience with September 2010 emergency rules, filing these emergency rule[s] now is necessary to allow DEL and the department of social and health services* to make system changes so that families may receive accurate child care subsidy eligibility and copayment determinations based upon the new standards taking effect on February 1, 2011.

Each month that DEL waits to implement child care subsidy eligibility revisions would result in more families who may be impacted by more severe cuts in child care subsidies. Revising eligibility requirements is expected to help the state avoid or delay additional budget cuts and the broad termination of child care subsidy benefits later in SFY 2011.

The governor has formally declared that a budget shortfall is imminent and has directed state agencies to implement 6.3 percent across-the-board spending cuts to avoid running out of state general funds. Executive Order 10-04 - Ordering Expenditure Reductions in Allotments of State General Fund Appropriations, signed on September 13, 2010, declared that:

- Revenues have fallen short of projections;
- The current official state economic and revenue forecast of general fund revenues is less than the official estimate upon which the state's 2009-2011 biennial operating budget and supplemental operating budget were enacted; and
- The anticipated revenues combined with the beginning cash balance of the general fund are insufficient to meet anticipated expenditures from this fund for the remainder of the current fiscal period (SFY 2011).

On December 15, 2010, Governor Gregoire announced proposed 2011-2013 budget cuts needed to close an additional $4.6 billion projected shortfall in the next state fiscal biennium, and proposed eliminating or restructuring many state programs, agencies, boards and commissions. "We face unprecedented times," the governor said. "Few alive today have witnessed a recession of this magnitude and length." See the governor's proposed budget for SFY 2011-2013 at this link http://www.governor.wa.gov/priorities/budget/press_packet.pdf.

The legislature's anticipated shortfall in the WorkFirst TANF box, combined with the Governor's Executive Order 10-04, demonstrate that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary both to the public interest and to the state's fiscal needs and requirements.

These rules replace emergency rules filed on December 17, 2010, as WSR 11-01-114. Filing substantially similar emergency rules in sequence is permitted under RCW 34.05.-350(2) if "*...conditions have changed or the agency has filed notice of its intent to adopt the rule as a permanent rule, and is actively undertaking the appropriate procedures to adopt the rule as a permanent rule.*"

DEL has filed a notice of intent to adopt permanent rules (see WSR 10-15-116 and 10-03-033). Proposed rules to implement the one hundred seventy-five percent of FPG income eligibility limit were filed in August 2010 (WSR 10-18-064) and public hearings were held in four locations around the state in October 2010. The department continues to monitor state revenue and WorkFirst caseload forecasts to determine if a revised rule proposal should be filed.

DEL has determined that the rules meet office of financial management guidance 3.c regarding the Governor's Executive Order 10-06 suspending noncritical rule making, but allowing rules to proceed that are "*... necessary to manage budget shortfalls, maintain fund solvency, or for revenue generating activities ...*"

**DEL and DSHS jointly operate the WCCC program, under section 501 (uncodified) chapter 265, Laws of 2006. DEL adopts WCCC policy and rules for the program. DSHS staff receive WCCC applications, determine family eligibility, and process child care subsidy payments.*

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 5, 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 5, Repealed 0.

Date Adopted: January 13, 2011.

Elizabeth M. Hyde
Director

AMENDATORY SECTION (Amending WSR 09-22-043, filed 10/28/09, effective 12/1/09)

WAC 170-290-0005 Consumers. (1) In WCCC, an eligible consumer has parental control of one or more children, lives in the state of Washington, and is the child's:

(a) Parent, either biological or adopted;

(b) Stepparent;

(c) Legal guardian verified by a legal or court document;

(d) Adult sibling or step-sibling;

(e) Nephew or niece;

(f) Aunt;

(g) Uncle;

(h) Grandparent; or

(i) Any of the relatives in (f), (g), or (h) of this subsection with the prefix great (for example, great-aunt).

(2) Consumers may be eligible for WCCC benefits if they:

(a) Meet eligibility requirements for WCCC described under part II of this chapter;

(b) Participate in an approved activity under WAC 170-290-0040, 170-290-0045, 170-290-0050, or have been approved per WAC 170-290-0055;

(c) Comply with any special circumstances that might affect WCCC eligibility under WAC 170-290-0020; and

(d) ((~~Have countable income at or below two hundred percent of the federal poverty guidelines (FPG) (under WAC 170-290-0065)~~)) Meet the following income eligibility limits:

(i) Effective January 1, 2011, consumers who are currently receiving child care subsidy benefits, initially applying for benefits before February 1, 2011, or reapplying for benefits before February 1, 2011, after a termination in benefits under WAC 170-290-0110:

(A) Must have countable income at or below one hundred seventy-five percent of the federal poverty guidelines (FPG); and

(B) Remain income eligible until their countable income is greater than one hundred seventy-five percent of the FPG; and

(ii) Effective February 1, 2011, consumers initially applying for benefits, or reapplying for benefits after a termination of benefits under WAC 170-290-0110:

(A) Must be determined eligible for, or receiving, a temporary assistance for needy families (TANF) grant; and

(B) Remain income eligible until their countable income is greater than one hundred seventy-five percent of the FPG, even if the consumer is no longer eligible to receive TANF.

(3) A consumer's eligibility shall end January 1, 2011, if a consumer's countable income is greater than one hundred seventy-five percent of the FPG.

(4) A consumer is not eligible for WCCC benefits when he or she:

(a) Is the only parent in the family and will be away from the home for more than thirty days in a row; or

(b) Has a monthly copayment that is higher than the rate the state will pay for all eligible children in care.

AMENDATORY SECTION (Amending WSR 09-22-043, filed 10/28/09, effective 12/1/09)

WAC 170-290-0075 Determining income eligibility and copayment amounts. (1) DSHS takes the following steps to determine a consumer's eligibility and copayment:

(a) Determine the consumer's family size (under WAC 170-290-0015); and

(b) Determine the consumer's countable income (under WAC 170-290-0065).

(2) Before February 1, 2011, if the consumer's family's countable monthly income falls within the range below, then his or her copayment is:

IF A CONSUMER'S INCOME IS:	THEN THE CONSUMER'S COPAYMENT IS:
(a) At or below 82% of the federal poverty guidelines (FPG)	$15
(b) Above 82% of the FPG up to 137.5% of the FPG	$50
(c) Above 137.5% of the FPG through ((~~200%~~)) 175% of the FPG	The dollar amount equal to subtracting 137.5% of FPG from countable income, multiplying by 44%, then adding $50
(d) Above ((~~200%~~)) 175% of the FPG, a consumer is not eligible for WCCC benefits.	

(3) On or after February 1, 2011, if the consumer's family countable income falls within the range below, then his or her copayment is:

IF A CONSUMER'S INCOME IS:	THEN THE CONSUMER'S COPAYMENT IS:
(a) At or below 82% of the federal poverty guidelines (FPG)	$15
(b) Above 82% of the FPG up to 137.5% of the FPG	$60
(c) Above 137.5% of the FPG through 175% of the FPG	The dollar amount equal to subtracting 137.5% of FPG from countable income, multiplying by 44%, then adding $60
(d) Above 175% of the FPG, a consumer is not eligible for WCCC benefits.	

(4) DSHS does not prorate the copayment when a consumer uses care for part of a month.

((~~(4)~~)) (5) The FPG is updated every year on April 1. The WCCC eligibility level is updated at the same time every year to remain current with the FPG.

AMENDATORY SECTION (Amending WSR 09-22-043, filed 10/28/09, effective 12/1/09)

WAC 170-290-0085 Change in copayment. (1) Once DSHS determines that a consumer is eligible for WCCC benefits, his or her copayment may change when:

(a) The consumer's monthly income decreases;

(b) The consumer's family size increases;

(c) DSHS makes an error in the consumer's copayment computation;

(d) The consumer did not report all income, activity and household information at the time of eligibility determination or application/reapplication;

(e) The consumer is no longer eligible for the minimum copayment under WAC 170-290-0090;

(f) DEL makes a mass change in benefits due to a change in law or program funding;

(g) The consumer is approved for a new eligibility period; or

(h) The consumer is approved for the fourteen-day wait period or twenty-eight-day gap period as provided in WAC 170-290-0055.

(2) If a consumer's copayment changes during his or her eligibility period, the change is effective on the first day of the month following DSHS becoming aware of the change.

(3) DSHS does not increase a consumer's copayment during his or her current eligibility period when his or her countable income remains at or below ((~~two hundred percent of the FPG~~)) the maximum eligibility limit as provided in WAC 170-290-0005 (2)(d) and (3), and:

(a) The consumer's monthly countable income increases; or

(b) The consumer's family size decreases.

AMENDATORY SECTION (Amending WSR 09-22-043, filed 10/28/09, effective 12/1/09)

WAC 170-290-3520 Eligible consumers. (1) In SCC, an eligible consumer ((~~is not currently receiving temporary aid for needy families (TANF),~~)) lives in the state of Washington, has parental control of one or more children, and is the child's:

(a) Parent, either biological or adopted;

(b) Stepparent;

(c) Legal guardian as verified by a legal or court document;

(d) Adult sibling or step-sibling;

(e) Aunt;

(f) Uncle;

(g) Niece or nephew;

(h) Grandparent; or

(i) Any of the above relatives in (e), (f), or (h) of this subsection, with the prefix "great," such as great-aunt.

(2) Consumers may be eligible for SCC benefits if they:

(a) Meet eligibility requirements in this chapter;

(b) Participate in an approved activity under WAC 170-290-3555; and

(c) Have countable income at or below ((~~two hundred percent of the federal poverty guidelines (FPG)~~)) the maximum eligibility limit described in WAC ((~~170-290-3640~~)) 170-290-0005 (2)(d) and (3).

(3) Consumers are not eligible for SCC benefits if they:

(a) Have a copayment, under WAC 170-290-0075, that is higher than the maximum monthly state rate for all of the consumer's children in care;

(b) Were employed with one employer more than eleven months in the previous twelve months; or

(c) ((~~Are receiving TANF benefits; or~~

~~(d)~~)) Are the only parent in the household and will be away from the home for more than thirty days in a row.

AMENDATORY SECTION (Amending WSR 09-22-043, filed 10/28/09, effective 12/1/09)

WAC 170-290-3640 Determining income eligibility and copayment. (1) For the SCC program, DEL determines a consumer's family's income eligibility and copayment by:

(a) The consumer's family size as defined under WAC 170-290-3540;

(b) The consumer's average monthly income as calculated under WAC 170-290-3620;

(c) The consumer's family's average monthly income as compared to the federal poverty guidelines (FPG); and

(d) The consumer's family's average monthly income as compared to the copayment chart defined in WAC 170-290-0075.

(2) If a consumer's family's income is above ((~~two hundred percent of the FPG as defined in WAC 170-290-0075~~)) the maximum eligibility limit as provided in WAC 170-290-0005 (2)(d) and (3), his or her family is not eligible for the SCC program.

(3) SCC does not prorate the copayment when a consumer uses care for part of a month.

(4) The FPG is updated every year on April 1. The SCC eligibility level is updated at the same time every year to remain current with the FPG.

(5) SCC shall assign a copayment amount based on the family's countable income. The copayment amount will be on the consumer's child care plan. The consumer pays the copayment directly to the provider.

WSR 11-03-047
RESCISSION OF EMERGENCY RULES
DEPARTMENT OF EARLY LEARNING

[Filed January 13, 2011, 2:57 p.m.]

The department of early learning (DEL) rescinds emergency rules filed as WSR 11-01-114, revising rules in chapter 170-290 WAC regarding the income limit for families applying for or receiving working connections child care or seasonal child care subsidy benefits, effective immediately upon this filing.

DEL has filed subsequent emergency rules, WSR 11-03-046, that will replace and supersede the rules filed as WSR 11-01-114.

Elizabeth M. Hyde
Director

WSR 11-03-051
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-11—Filed January 14, 2011, 8:51 a.m., effective January 20, 2011, 12:01 p.m.]

Effective Date of Rule: January 20, 2011, 12:01 p.m.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000N; and amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1, 2 and those portions of Razor Clam Area 3 open for harvest. Washington department of health has certified clams from these beaches to be safe for human consumption. There is insufficient time to adopt permanent rules.

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 1.

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: January 14, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000N Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 2, or 3, except as provided for in this section:

1. Effective 12:01 p.m. January 20 through 11:59 p.m. January 22, 2011, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

2. Effective 12:01 p.m. January 20 through 11:59 p.m. January 22, 2011, razor clam digging is allowed in Razor Clam Area 2. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

3. Effective 12:01 p.m. January 21 through 11:59 p.m. January 22, 2011, razor clam digging is allowed in that portion Razor Clam Area 3 that is between Olympic National Park South Beach Campground access road (Kalaloch area, Jefferson County) and Browns Point (Kalaloch area, Jefferson County). Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

4. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

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.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. January 23, 2011:

WAC 220-56-36000N	Razor clams—Areas and seasons.