WSR 11-14-052
PERMANENT RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)
[Filed June 29, 2011, 12:18 p.m., effective August 1, 2011]

Effective Date of Rule: August 1, 2011.

Purpose: These proposed amendments to chapter 388-543 WAC, Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services are necessary in order to reorganize the order of the rules to easier use, to eliminate duplicate information, to propose clearer titles, offer a more logical flow, remove old acronyms, cross references, definitions, update coverage policy, update documentation requirements, update client eligibility, clarify proof of delivery requirements, update reimbursement methodology, clarify rental verses purchase, clarify a valid prescription, update authorization requirements, and clarified limits.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-543-1150, 388-543-1200, 388-543-1225, 388-543-1300, 388-543-1400, 388-543-1500, 388-543-1600, 388-543-1700, 388-543-1800, 388-543-1900, 388-543-2400, 388-543-2500, 388-543-2600, 388-543-2700, 388-543-2800 and 388-543-2900; amending WAC 388-543-1000, 388-543-1100, 388-543-2000, 388-543-2100, 388-543-2200, and 388-543-3000.

Statutory Authority for Adoption: RCW 74.08.090.

Other Authority: RCW 74.04.050.

Adopted under notice filed as WSR 11-08-070 on April 6, 2011.

Changes Other than Editing from Proposed to Adopted Version: **WAC 388-543-5500 (4)(d) Covered—Medical supplies and related services,** the department fixed an erroneous cross reference:

(4) Blood monitoring/testing supplies:

(d) See WAC 388-543-5500 ~~(13)~~ (12) for blood glucose monitors.

WAC 388-543-5500 (12)(b) Covered—Medical supplies and related services, the department added clarifying language regarding continuous glucose monitoring.

(12) Miscellaneous DME:

(b) Blood glucose monitor (specialized or home) - one in a three-year period. See WAC 388-543-5500(4) for blood monitoring/testing supplies. The department does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC 388-553-500 Home infusion therapy/parenteral nutrition program.

A final cost-benefit analysis is available by contacting Erin Mayo, P.O. Box 45504, Olympia, WA 98504-5504, phone (360) 725-1729, fax (360) 586-9727, e-mail Erin.Mayo@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 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 27, Amended 6, Repealed 16.

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 27, Amended 6, Repealed 16.

Date Adopted: June 27, 2011.

Susan N. Dreyfus
Secretary

NEW SECTION

WAC 388-543-0500 DME and related supplies, prosthetics, orthotics, medical supplies and related services—General. (1) The federal government considers durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies as optional services under the medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The department may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(2) The department covers the DME and related supplies, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter.

(3) The department pays for DME and related supplies, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies when it is:

(a) Covered;

(b) Within the scope of the client's medical program (see WAC 388-501-0060 and WAC 388-501-0065);

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

(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC) within the scope of his or her licensure, except for dual eligible medicare/medicaid clients when medicare is the primary payer and the department is being billed for a co-pay and/or deductible only;

(e) Authorized, as required within this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda;

(f) Billed according to this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memorandum; and

(g) Provided and used within accepted medical or physical medicine community standards of practice.

(4) The department requires prior authorization for covered DME and related supplies, prosthetics, orthotics, medical supplies, and related services when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The department evaluates requests requiring prior authorization on a case-by-case basis to determine medical necessity, according to the process found in WAC 388-501-0165.

(b) Refer to WAC 388-543-7000, 388-543-7001, and 388-543-7003 for specific details regarding authorization.

(5) The department bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies, and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 388-543-7100 for PA and WAC 388-543-7300 for EPA). The department considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(6) The department evaluates a request for any DME item listed as noncovered in this chapter under the provisions of WAC 388-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-543-0100 for EPSDT rules).

(7) The department may terminate a provider's participation with the department according to WAC 388-502-0030 and 388-502-0040.

(8) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under the provisions of WAC 388-501-0165.

AMENDATORY SECTION (Amending WSR 02-16-054, filed 8/1/02, effective 9/1/02)

WAC 388-543-1000 ((~~Definitions for durable medical equipment (~~))DME((~~)~~)) and related supplies, prosthetics, and orthotics, medical supplies and related services— Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

((~~**"Artificial limb" -** See "prosthetic device."~~

~~**"Augmentative communication device (ACD)" -** See "speech generating device (SGD)."~~

~~**"Base year"** means the year of the data source used in calculating prices.~~))

"By report (BR)" ((~~means a method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees~~)) A method of payment in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. The provider must submit a report which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Date of delivery" ((~~means~~)) - The date the client actually took physical possession of an item or equipment.

"Digitized speech" (also referred to as devices with whole message speech output) - Words or phrases that have been recorded by an individual other than the speech generating device (SGD) user for playback upon command of the SGD user.

"Disposable supplies" ((~~means~~)) - Supplies which may be used once, or more than once, but are time limited.

"Durable medical equipment (DME)" ((~~means~~)) - Equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"EPSDT" - See WAC 388-500-0005.

"Expedited prior authorization (EPA)" ((~~means~~)) - The process for obtaining authorization for selected ((~~durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related~~)) healthcare services((~~,~~)) in which providers use a set of numeric codes to indicate to ((~~MAA~~)) the department which acceptable ((~~indications/conditions/MAA-defined~~)) indications, conditions, or department-defined criteria are applicable to a particular request for ((~~DME~~)) authorization. EPA is a form of prior authorization.

"Fee-for-service (FFS)" ((~~means~~)) - The general payment method ((~~MAA~~)) the department uses to ((~~reimburse~~)) pay for covered medical services provided to clients, except those services covered under ((~~MAA's~~)) the department's prepaid managed care programs.

"((~~Health care financing administration~~)) Healthcare common procedure coding system (HCPCS)" ((~~means~~)) - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"Home" - For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client receives care.

"House wheelchair" ((~~means~~)) - A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Limitation extension" ((~~means a process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization~~)) - A client-specific authorization by the department for additional covered services beyond the set amount allowed under department rules. See WAC 388-501-0169.

((~~**"Nonreusable supplies"** are disposable supplies, which are used once and discarded.~~))

"Manual wheelchair" - See "wheelchair - manual."

"Medical supplies" ((~~means~~)) - Supplies that are:

(1) Primarily and customarily used to service a medical purpose; and

(2) Generally not useful to a person in the absence of illness or injury.

"Medically necessary" - See WAC 388-500-0005.

"National provider indicator (NPI)" - A federal system for uniquely identifying all providers of healthcare services, supplies, and equipment.

"Other durable medical equipment (other DME)" - All durable medical equipment, excluding wheelchairs and wheelchair-related items.

"Orthotic device" or **"orthotic"** ((~~means~~)) - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Personal or comfort item" ((~~means~~)) - An item or service which primarily serves the comfort or convenience of the client or caregiver.

((~~**"Personal computer (PC)"** means any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations).~~))

"Power-drive wheelchair" - See "wheelchair - power."

"Pricing cluster" - A group of manufacturers' list prices for brands/models of DME, medical supplies and nondurable medical equipment that the department considers when calculating the reimbursement rate for a procedure code that does not have a fee established by medicare.

"Prior authorization" ((~~means process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165~~)) The requirement that a provider must request, on behalf of a client and when required by rule, the department's approval to render a healthcare service or write a prescription in advance of the client receiving the healthcare service or prescribed drug, device, or drug-related supply. The department's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

"Prosthetic device" or **"prosthetic"** ((~~means~~)) - A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Resource-based relative value scale (RBRVS)" ((~~means~~)) - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"Reusable supplies" ((~~are~~)) - Supplies which are to be used more than once.

"Scooter" ((~~means~~)) - A federally-approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

"Specialty bed" ((~~means~~)) - A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" ((~~means~~)) - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Synthesized speech" - Is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules, unlike prerecorded messages of digitized speech. A SGD that has synthesized speech is not limited to prerecorded messages but rather can independently create messages as communication needs dictate.

"Three- or four-wheeled scooter" ((~~means~~)) - A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

"Trendelenburg position" ((~~means~~)) - A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" ((~~means~~)) - The amount the provider typically charges to fifty percent or more of his or her ((~~nonmedicaid clients, including clients with other third-party coverage~~)) patients who are not medical assistance clients.

((~~**"Warranty wheelchair"** means a warranty~~)) **"Warranty-period"** - A guarantee or assurance, according to manufacturers' or provider's guidelines, of ((~~not less than one year~~)) set duration from the date of purchase.

"Wheelchair - manual" ((~~means~~)) - A federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(1) Standard:

(a) Usually is not capable of being modified;

(b) Accommodates a person weighing up to two hundred fifty pounds; and

(c) Has a warranty period of at least one year.

(2) Lightweight:

(a) Composed of lightweight materials;

(b) Capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds; and

(d) Usually has a warranty period of at least three years.

(3) High-strength lightweight:

(a) Is usually made of a composite material;

(b) Is capable of being modified;

(c) Accommodates a person weighing up to two hundred fifty pounds;

(d) Has an extended warranty period of over three years; and

(e) Accommodates the very active person.

(4) Hemi:

(a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(8) Heavy duty:

(a) Specifically manufactured to support a person weighing up to three hundred pounds; or

(b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(10) Custom heavy duty:

(a) Specifically manufactured to support a person weighing over three hundred pounds; or

(b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(11) Custom manufactured specially built:

(a) Ordered for a specific client from custom measurements; and

(b) Is assembled primarily at the manufacturer's factory.

"Wheelchair - power" ((~~means~~)) - A federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(a) Alternative driving controls; and

(b) Power recline and tilt-in-space systems.

(2) Noncustom power: Does not need special positioning or controls and has a standard frame.

(3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

AMENDATORY SECTION (Amending WSR 07-17-062, filed 8/13/07, effective 9/13/07)

WAC 388-543-1100 ((~~Scope of coverage and coverage limitations for~~)) DME and related supplies, prosthetics, orthotics, medical supplies and related services—Client eligibility. ((~~The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics**, **orthotics**, and **medical supplies** as optional services under the **medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment **(EPSDT)** program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.~~

~~(1) The department covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when they are:~~

~~(a) Within the scope of an eligible client's medical care program (see WAC 388-501-0060 and 388-501-0065);~~

~~(b) Within accepted medical or physical medicine community standards of practice;~~

~~(c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;~~

~~(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC). Except for dual eligible medicare/medicaid clients when medicare is the primary payer and the department is being billed for co-pay and/or deductible only:~~

~~(i) The prescriber must use DSHS 13-794 (Health and Recovery Services (HRSA) Prescription Form) to write the prescription. The form is available for download at http://www1.dshs.wa.gov/msa/forms/eforms.html; and;~~

~~(ii) The prescription (DSHS 13-794) must:~~

~~(A) Be signed and dated by the prescriber;~~

~~(B) Be no older than one year from the date the prescriber signs the prescription; and~~

~~(C) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity;~~

~~(e) Billed to the department as the payor of last resort only. The department does not pay first and then collect from medicare and;~~

~~(f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:~~

~~(i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, ARNP, PAC, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; and/or~~

~~(ii) Video and/or photograph(s) of the client demonstrating the impairments as well and client's ability to use the requested equipment, when applicable.~~

~~(2) The department evaluates a request for any equipment or device listed as noncovered in WAC 388-543-1300 under the provisions of WAC 388-501-0160.~~

~~(3) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165.~~

~~(4) The department evaluates requests for covered services in this chapter that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.~~

~~(5) The department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:~~

~~(a) An inpatient hospital client;~~

~~(b) Eligible for both **medicare** and medicaid, and is staying in a **nursing facility** in lieu of hospitalization;~~

~~(c) Terminally ill and receiving hospice care; or~~

~~(d) Enrolled in a risk based managed care plan that includes coverage for such items and/or services.~~

~~(6) The department covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in the department's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.~~

~~(7) An interested party may request the department to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:~~

~~(a) Manufacturer's literature;~~

~~(b) Manufacturer's pricing;~~

~~(c) Clinical research/case studies (including FDA approval, if required); and~~

~~(d) Any additional information the requester feels is important.~~

~~(8) The department bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.~~

~~(9) The department covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.~~

~~(10) The department covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician, ARNP, or PAC, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:~~

~~(a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;~~

~~(b) Wheelchairs and other DME;~~

~~(c) Prosthetic/orthotic devices;~~

~~(d) Surgical/ostomy appliances and urological supplies;~~

~~(e) Bandages, dressings, and tapes;~~

~~(f) Equipment and supplies for the management of diabetes; and~~

~~(g) Other medical equipment and supplies listed in department published issuances.~~

~~(11) The department evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.~~

~~(12) For a client in a **nursing facility,** the department covers only the following when medically necessary. All other DME and supplies identified in the department's billing instructions are the responsibility of the nursing facility, in accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4).~~

~~(a) The department covers:~~

~~(i) The purchase and repair of a speech generating device (SGD) and one of the following:~~

~~(A) A powered or manual wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate; or~~

~~(B) A specialty bed or the rental of a specialty bed outside of the skilled nursing facility per diem when:~~

~~(I) The specialty bed is intended to help the client heal; and~~

~~(II) The client's nutrition and laboratory values are within normal limits.~~

~~(b) A heavy duty bariatric bed is not considered a specialty bed.~~

~~(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.~~

~~(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice~~)) (1) Durable medical equipment (DME) and related services, prosthetics and orthotics, medical supplies and related services are available to clients who are eligible for services under one of the following medical assistance programs:

(a) Categorically needy (CN);

(b) Children's healthcare as described in WAC 388-505-0210;

(c) Medically needy (MN);

(d) Disability lifeline (formerly GA U/ADATSA) (within Washington state or designated border cities); or

(e) Alien emergency medical (AEM) as described in WAC 388-438-0110, when the medical services are necessary to treat a qualifying emergency medical condition.

(2) Clients who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for DME and related services, prosthetics and orthotics, medical supplies and related services.

(3) Clients who are enrolled in a department contracted managed care organization (MCO) must arrange for DME and related services, prosthetics and orthotics, medical supplies and related services directly through his or her department-contracted MCO. The department does not pay for medical equipment and/or services provided to a client who is enrolled in a department-contracted MCO, but chose not to use one of the MCO's participating providers.

(4) For clients who reside in a skilled nursing facility, see WAC 388-543-5700.

AMENDATORY SECTION (Amending WSR 07-17-062, filed 8/13/07, effective 9/13/07)

WAC 388-543-2000 ((~~Wheelchairs~~)) DME and related supplies, prosthetics, orthotics, medical supplies and related services—Eligible providers and provider requirements. (1) The department ((~~bases its decisions regarding requests for wheelchairs on medical necessity and on a case-by-case basis.~~

~~(2) The following apply when the department determines that a wheelchair is medically necessary for six months or less:~~

~~(a) If the client lives at home, the department rents a wheelchair for the client; or~~

(b) If the client lives in a nursing facility, the nursing facility must provide a **house wheelchair** as part of the per diem rate paid by the aging and disability services administration (ADSA).

(3) The department considers rental or purchase of a **manual wheelchair** for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. The department determines the type of manual wheelchair based on the following:

(a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

(b) A standard lightweight wheelchair if the client's medical condition is such that the client:

(i) Cannot self-propel a standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.

(c) A high-strength lightweight wheelchair for a client:

(i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing up to three hundred pounds; or

(ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing over three hundred pounds; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

(4) The department considers a **power drive wheelchair** when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

(a) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(b) A power-drive wheelchair will provide the client the only means of independent mobility; or

(c) A power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

(d) All other circumstances will be considered based on medical necessity and on a case-by-case basis.

(e) The following additional information is required for a three or four-wheeled power-drive scooter/cart:

(i) The prescribing physician certifies that the client's condition is stable; and

(ii) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(5) The department considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

(6) In order to consider purchasing a wheelchair, the department requires the provider to submit the following information from the prescribing physician, physical therapist, or occupational therapist:

(a) Specific medical justification for the make and model of wheelchair requested;

(b) Define the degree and extent of the client's impairment (such as stage of decubitus, severity of spasticity or flaccidity, degree of kyphosis or scoliosis); and

(c) Documented outcomes of less expensive alternatives (aids to mobility) that have been tried by the client.

(7) In addition to the basic wheelchair, the department may consider wheelchair accessories or modifications that are specifically identified by the manufacturer as separate line item charges. The provider must submit specific medical justification for each line item, with the modification request.

(8) The department considers wheelchair modifications to a medically necessary wheelchair when the provider submits all of the following with the modification request:

(a) The make, model, and serial number of the wheelchair to be modified;

(b) The modification requested; and

(c) Specific information regarding the client's medical condition that necessitates the modification.

(9) The department may consider wheelchair repairs to a medically necessary wheelchair; the provider must submit to the department the make, model, and serial number of the wheelchair for which the repairs are requested.

(10) The department may cover two wheelchairs, a manual wheelchair and a power drive wheelchair, for a noninstitutionalized client in certain situations. One of the following must apply:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness;

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, the department requires the client's situation to meet the following conditions:

~~(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and~~

~~(ii) Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.~~

~~(iii) All other circumstances will be considered on a case-by-case basis, based on medical necessity~~)) pays qualified providers for durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service basis as follows:

(a) DME providers for DME and related repair services;

(b) Medical equipment dealers, pharmacies, and home health agencies under their national provider indicator (NPI) for medical supplies;

(c) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only;

(d) Physicians who provide medical equipment and supplies in the office. The department may pay separately for medical supplies, subject to the provisions in the department's resource-based relative value scale fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(2) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related items must:

(a) Meet the general provider requirements in chapter 388-502 WAC;

(b) Have the proper business license and be certified, licensed and/or bonded if required, to perform the services billed to the department;

(c) Have a valid prescription;

(i) To be valid, a prescription must:

(A) Be written on the department's Prescription Form (DSHS 13-794). The department's electronic forms are available online at: http://www.dshs.wa.gov/msa/forms/eforms.html;

(B) Be written by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC);

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual eligible medicare/medicaid clients when medicare is the primary payer and the department is being billed for the co-pay and/or deductible only, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Furnish only new equipment to clients that includes full manufacturer and dealer warranties. See WAC 388-543-2250(3);

(f) Furnish documentation of proof of delivery, upon department request (see WAC 388-543-2200); and

(g) Bill the department using only the allowed procedure codes listed in published DME and related supplies, prosthetics and orthotics, medical supplies and related items billing instructions.

AMENDATORY SECTION (Amending WSR 03-19-083, filed 9/12/03, effective 10/13/03)

WAC 388-543-2100 ((~~Wheelchairs—Reimbursement methodology~~)) DME and related supplies, prosthetics, orthotics, medical supplies and related services—Requests to include new equipment/supplies/technology. (1) ((~~MAA reimburses a DME provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:~~

~~(a) The client's medical needs;~~

~~(b) Product quality;~~

~~(c) Cost; and~~

~~(d) Available alternatives.~~

~~(2) For wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses either:~~

~~(a) The medicare fees that are current on April 1 of each year; or~~

~~(b) MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the **base year,** or the invoice for the specific item. MAA uses the following percentages:~~

~~(i) For basic standard wheelchairs, sixty-five percent;~~

~~(ii) For add-on accessories and parts, eighty-four percent;~~

~~(iii) For upcharge modifications and cushions, eighty percent;~~

~~(iv) For all other manual wheelchairs, eighty percent; and~~

~~(v) For all other power-drive wheelchairs, eighty-five percent.~~

~~(3) MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or medicare rates.~~

~~(4) MAA evaluates and updates the wheelchair fee schedule once per year.~~

~~(5) MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change~~)) An interested party may request the department to include new equipment/supplies in the department's durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related services billing instructions.

(2) The request should include credible evidence, including but not limited to:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (included FDA approval, if required);

(d) Proof of certification from the centers for medicare and medicaid services (CMS), if applicable; and

(e) Any additional information the requester feels would aid the department in its determination

(3) Requests should be sent to the DME Program Management Unit, PO Box 45505, Olympia WA 98504-5506.

AMENDATORY SECTION (Amending WSR 02-16-054, filed 8/1/02, effective 9/1/02)

WAC 388-543-2200 ((~~Speech generating devices (SGD)~~)) DME and related supplies, prosthetics, orthotics, medical supplies and related services—Proof of delivery. (1) ((~~MAA considers all requests for speech generating devices (SGDs) on a case-by-case basis. The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).~~

~~(2) In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment, and have one of the following characteristics. For the purposes of this section, MAA uses the medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:~~

~~(a) Digitized speech output, using pre-recorded messages;~~

~~(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or~~

~~(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.~~

~~(3) MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:~~

~~(a) A detailed description of the client's therapeutic history, including, at a minimum:~~

~~(i) The medical diagnosis;~~

~~(ii) A physiological description of the underlying disorder;~~

~~(iii) A description of the functional limitations; and~~

~~(iv) The prognosis for improvement or degeneration.~~

~~(b) A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:~~

~~(i) If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, an assessment by the prescribing physician, licensed occupational therapist or physical therapist;~~

~~(ii) Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;~~

~~(iii) The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;~~

~~(iv) An assessment of whether the client's daily communication needs could be met using other natural modes of communication;~~

~~(v) A description of the functional communication goals expected to be achieved, and treatment options;~~

~~(vi) Documentation that the client's speaking needs cannot be met using natural communication methods; and~~

~~(vii) Documentation that other forms of treatment have been ruled out.~~

~~(c) The provider has shown or has demonstrated all of the following:~~

~~(i) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;~~

~~(ii) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and~~

~~(iii) The client's treatment plan includes a training schedule for the selected device.~~

~~(d) A prescription for the SGD from the client's treating physician.~~

~~(4) MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.~~

~~(5) MAA covers SGDs only once every two years for a client who meets the criteria in subsection (3) of this section. MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the criteria in this subsection based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.~~

~~(6) Clients who are eligible for both medicare and medicaid must apply first to medicare for an SGD. If medicare denies the request and the client requests an SGD from MAA, MAA evaluates the request based on medical necessity and the requirements in this section. The request for an SGD must meet the authorization requirements in this section~~)) When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the department requests that information. All of the following apply:

(a) The department requires a delivery slip as proof of delivery, and it must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For durable medical equipment (DME) that may require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to the department, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or the client's authorized representative; or

(ii) For nondurable medical supplies for which the department has established a monthly maximum, on or after the date the item was received by the client or the client's authorized representative.

(2) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must furnish proof of delivery that the client received the equipment and/or supply, when the department requests that information.

(a) If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery. The tracking slip must include:

(i) The client's name or a reference to the client's package(s);

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) If the provider/supplier does the delivering, the delivery slip is the proof of delivery. The delivery slip must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand name(s) of the items being shipped; and

(iv) For DME that may require future repairs, the serial number.

(c) When billing the department:

(i) Use the shipping date as the date of service on the claim if the provider uses a delivery/shipping service; or

(ii) Use the actual date of delivery as the date of service on the claim if the provider/supplier does the delivery.

(3) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(4) Providers must obtain prior authorization when required before delivering the item to the client. The item must be delivered to the client before the provider bills the department.

(5) The department does not pay for DME and related supplies, prosthetics and orthotics, medical supplies and related items furnished to the department's clients when:

(a) The medical professional who provides medical justification to the department for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of DME and related supplies, prosthetics and orthotics, medical supplies, and related items.

NEW SECTION

WAC 388-543-2250 DME and related supplies, prosthetics, orthotics, medical supplies and related services—Rental or purchase. (1) The department bases its decision to rent or purchase durable medical equipment (DME) on the length of time the client needs the equipment.

(2) A provider must not bill the department for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(3) The department purchases new DME equipment only.

(a) A new DME item that is placed with a client initially as a rental item is considered a new item by the department at the time of purchase.

(b) A used DME item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the department.

(4) The department requires a dispensing provider to ensure the DME rented to a client is:

(a) In good working order; and

(b) Comparable to equipment the provider rents to individuals with similar medical equipment needs who are either private pay or who have other third-party coverage.

(5) The department's minimum rental period for covered DME is one day.

(6) The department authorizes rental equipment for a specific period of time. The provider must request authorization from the department for any extension of the rental period.

(7) The department's reimbursement amount for rented DME includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(8) The department considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.

(9) DME and related supplies, prosthetics, and orthotics purchased by the department for a client are the client's property.

(10) The department rents, but does not purchase, certain DME for clients. This includes, but is not limited to, the following:

(a) Bilirubin lights for newborns at home with jaundice; and

(b) Electric hospital-grade breast pumps.

(11) The department stops paying for any rented equipment effective the date of a client's death. The department prorates monthly rentals as appropriate.

(12) For a client who is eligible for both medicare and medicaid, the department pays only the client's coinsurance and deductibles. The department discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:

(a) The reimbursement amount reaches medicare's reimbursement cap for the equipment; or

(b) Medicare considers the equipment purchased.

(13) The department does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

AMENDATORY SECTION (Amending WSR 01-01-078, filed 12/13/00, effective 1/13/01)

WAC 388-543-3000 ((~~DME and supplies provided in physician's office~~)) Covered—Hospital beds, mattresses, and related equipment. ((~~MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the RBRVS, when it is appropriate~~)) (1) Hospital beds.

(a) The department covers, with prior authorization, one hospital bed in a ten-year period, per client, with the following limitations:

(i) A manual hospital bed as the primary option when the client has full-time caregivers; or

(ii) A semi-electric hospital bed only when:

(A) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed and the position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(B) The client's medical condition requires immediate position changes;

(C) The client is able to operate the controls independently; and

(D) The client needs to be in the Trendelenburg position.

(b) The department bases the decision to rent or purchase a manual or semi-electric hospital bed on the length of time the client needs the bed.

(c) Rental - The department pays up to eleven months continuous rental of a hospital bed in a twelve-month period as follows:

(i) A manual hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

(A) Has a length of need/life expectancy that is twelve months or less;

(B) Has a medical condition that requires positioning of the body that cannot be accomplished in a standard bed (reason must be documented in the client's file);

(C) Has tried pillows, bolsters, and/or rolled up blankets/towels in client's own bed, and determined to not be effective in meeting the client's positioning needs (nature of ineffectiveness must be documented in the client's file);

(D) Has a medical condition that necessitates upper body positioning at no less than a thirty-degree angle the majority of time the client is in the bed;

(E) Does not have full-time caregivers; and

(F) Does not also have a rental wheelchair.

(ii) A semi-electric hospital bed with mattress, with or without bed rails. The client must meet all of the following clinical criteria:

(A) Has a length of need/life expectancy that is twelve months or less;

(B) Has tried pillows, bolsters, and/or rolled up blankets/towels in own bed, and determined ineffective in meeting positioning needs (nature of ineffectiveness must be documented in the client's file);

(C) Has a chronic or terminal condition such as chronic obstructive pulmonary disease (COPD), congestive health failure (CHF), lung cancer or cancer that has metastasized to the lungs, or other pulmonary conditions that cause the need for immediate upper body elevation;

(D) Must be able to independently and safely operate the bed controls; and

(E) Does not have a rental wheelchair.

(d) Purchase - The department pays, with prior authorization, for the initial purchase of a semi-electric hospital bed with mattress, with or without bed rails, when the following criteria are met:

(i) The client:

(A) Has a length of need/life expectancy that is twelve months or more;

(B) Has tried positioning devices such as pillows, bolsters, foam wedges, and/or rolled up blankets/towels in own bed, and been determined ineffective in meeting positioning needs (nature if ineffectiveness must be documented in the client's file);

(C) Must be able to independently and safely operate the bed controls; and

(D) Is diagnosed:

(I) With quadriplegia;

(II) With tetraplegia;

(III) With duchenne muscular dystrophy;

(IV) With amyotrophic lateral sclerosis (ALS), often referred to as "Lou Gehrig's Disease";

(V) As ventilator-dependent; or

(VI) With chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) with aspiration risk or shortness of breath that causes the need for an immediate change of more than thirty degrees.

(ii) Requests for prior authorization must be submitted in writing to the department and be accompanied by:

(A) A completed General Information for Authorization form (DSHS 13-835) and Hospital Bed Evaluation form (DSHS 13-747). The department's electronic forms are available online (see WAC 388-543-7000 Authorization);

(B) Documentation of the client's life expectancy, in months and/or years, the client's diagnosis, the client's date of delivery and serial number of the hospital bed; and

(C) Be accompanied by written documentation, from the client or caregiver, indicating the client has not been previously provided a hospital bed, purchase or rental.

(2) Mattresses and related equipment - The department pays, with prior authorization, for the following:

(a) Pressure pad, alternating with pump - one in a five-year period;

(b) Dry pressure mattress - one in a five-year period;

(c) Gel or gel-like pressure pad for mattress - one in a five-year period;

(d) Gel pressure mattress - one in a five-year period;

(e) Water pressure pad for mattress - one in a five-year period;

(f) Dry pressure pad for mattress - one in a five-year period;

(g) Mattress, inner spring - one in a five-year period; and

(h) Mattress, foam rubber - one in a five-year period.

NEW SECTION

WAC 388-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards. The department covers the purchase of the following with the stated limitations, without prior authorization:

(1) Patient lift, hydraulic, with seat or sling - one per client in a five-year period.

(2) Traction equipment - one per client in a five-year period.

(3) Trapeze bars - one per client in a five-year period. The department requires prior authorization for rental.

(4) Fracture frames - one per client in a five-year period. The department requires prior authorization for rental.

(5) Transfer board or devices - one per client in a five-year period.

NEW SECTION

WAC 388-543-3200 Covered—Positioning devices. The department covers, without prior authorization, positioning devices with the following limitations:

(1) Positioning system/supine board (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one per client in a five-year period.

(2) Prone stander (infant, child, youth, or adult size) - one per client is a five-year period. The prone stander must be prescribed by a physician and the client must not be residing in a skilled nursing facility.

(3) Adjustable standing frame (for child/adult who is thirty to sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - one per client in a five-year period.

(4) Positioning car seats - one per client, eight years of age and older or four feet nine inches or taller, in a five-year period.

NEW SECTION

WAC 388-543-3300 Covered—Osteogenesis electrical stimulator (bone growth stimulator). (1) The department covers, with prior authorization, noninvasive osteogenesis electrical stimulators, limited to one per client, in a five-year period.

(2) The department pays for the purchase of non-spinal bone growth stimulators, only when:

(a) The stimulators have pulsed electromagnetic field (PEMF) simulation; and

(b) The client meets one or more of the following clinical criteria:

(i) Has a nonunion of a long bone fracture (which includes clavicle, humerus, phalanx, radius, ulna, femur, tibia, fibula, metacarpal and metatarsal) after three months have elapsed since the date of injury without healing; or

(ii) Has a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery.

(3) The department pays for the purchase of spinal bone growth stimulators, when:

(a) Prescribed by a neurologist, an orthopedic surgeon, or a neurosurgeon and;

(b) The client meets one or more of the following clinical criteria:

(i) Has a failed spinal fusion where a minimum of nine months have elapsed since the last surgery; or

(ii) Is post-op from a multilevel spinal fusion surgery; or

(iii) Is post-op from spinal fusion surgery where there is a history of a previously failed spinal fusion.

NEW SECTION

WAC 388-543-3400 Covered—Communication devices/speech generating devices (SGD). (1) The department covers:

(a) One artificial larynx, any type, without prior authorization, per client in a five-year period; and

(b) One speech generating device (SGD), with prior authorization, per client every two years.

(2) The department pays only for those approved speech generating devices (SGDs) that have:

(a) Digitized speech output, using pre-recorded messages;

(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or

(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

(3) The department requires prior authorization for SGDs and reviews requests on a case-by-case basis. Requests to the department for prior authorization must meet all of the following:

(a) The client must have a severe expressive speech impairment and the client's medical condition warrants the use of a device to replace verbal communication (e.g., to communicate medical information); and

(b) The request must be in writing and be accompanied by:

(i) A completed General Information for Authorization form (DSHS 13-835). The department's electronic forms are available online (see WAC 388-543-7000 Authorization); and

(ii) A completed Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices form (DSHS 15-310). The department requires, at a minimum, the following information:

(A) A detailed description of the client's therapeutic history;

(B) A written assessment by a licensed speech language pathologist (SLP); and

(C) Documentation of all of the following:

(I) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;

(II) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and

(III) The client's treatment plan includes a training schedule for the selected device.

(iii) A copy of the prescription for the SGD from the client's treating physician written on a department Prescription form (DSHS 13-794) (see WAC 388-543-2000(2)).

(4) The department may require trial-use rental of a SGD. The department applies the rental costs for the trial-use to the purchase price.

(5) The department pays for the repair or modification of an SGD when all of the following are met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new SGD and the provider has supporting documentation; and

(c) The repair has a warranty for a minimum of ninety days.

(6) The department does not pay for devices requested for the purpose of education.

(7) The department pays for replacement batteries for a SGD in accordance with WAC 388-543-5500(3). The department does not pay for back-up batteries for a SGD.

(8) Clients who are eligible for both medicare and medicaid must apply first to medicare for an SGD. If medicare denies the request and the client requests an SGD from the department, the department evaluates the request according to the rules of this section.

NEW SECTION

WAC 388-543-3500 Covered—Ambulatory aids (canes, crutches, walkers, related supplies). (1) The department covers the purchase of the following ambulatory aids with stated limitations, without prior authorization:

(a) Canes - one per client in a five-year period.

(b) Crutches - one per client in a five-year period.

(c) Walkers - one per client in a five-year period.

(2) The department pays for replacement underarm pads for crutches and replacement handgrips and tips for canes, crutches, and walkers. Prior authorization is not required.

NEW SECTION

WAC 388-543-4000 Covered—Wheelchairs—General. (1) The department covers, with prior authorization, manual and power-drive wheelchairs for clients who reside at home. For clients who reside in a skilled nursing facility, see WAC 388-543-5700.

(2) For manual or power-drive wheelchairs for clients who reside at home, requests for prior authorization must include all of the following completed forms:

(a) General Information for Authorization form (DSHS 13-835). The department's electronic forms are available online (see WAC 388-543-7000 Authorization);

(b) A Prescription form (DSHS 13-794); and

(c) Medical Necessity for Wheelchair Purchase (for home clients only) form (DSHS 13-727) from the client's physician or therapist. The date on this form (DSHS 13-727) must not be prior to the date on the Prescription form (DSHS-13-794).

(3) The department does not pay for manual or power-drive wheelchairs that have been delivered to a client without prior authorization from the department.

(4) When the department determines that a wheelchair is medically necessary, according to the process found in WAC 388-501-0165, for six months or less, the department rents a wheelchair for clients who live at home. For clients who reside in a skilled nursing facility, see WAC 388-543-5700.

NEW SECTION

WAC 388-543-4100 Covered—Wheelchairs—Manual. The department covers the rental or purchase of a manual wheelchair for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. For clients who reside in a skilled nursing facility, see WAC 388-543-5700.

(1) The department determines the type of manual wheelchair for a home client as follows:

(a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

(b) A standard lightweight wheelchair if the client's medical condition is such that the client:

(i) Cannot self-propel a standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.

(c) A high-strength lightweight wheelchair for a client:

(i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing three hundred pounds or over; or

(ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing three hundred pounds or over; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self-propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the categories of wheelchairs listed in this section.

(h) Pediatric wheelchairs/positioning strollers having a narrower seat and shorter depths more suited to pediatric patients, usually adaptable to modifications for a growing child.

(2) The department pays for both a manual wheelchair and a power-drive wheelchair only for noninstitutionalized clients in limited circumstances. See WAC 388-543-4200(5).

NEW SECTION

WAC 388-543-4200 Covered—Wheelchairs—Power-drive. (1) The department covers power-drive wheelchairs when the prescribing physician certifies that the following clinical criteria are met:

(a) The client can independently and safely operate a power-drive wheelchair;

(b) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(c) A power-drive wheelchair will:

(i) Provide the client the only means of independent mobility; or

(ii) Enable a child to achieve age-appropriate independence and developmental milestones.

(2) The following additional information is required for a three or four-wheeled power-drive scooter/power-operated vehicle (POV):

(a) The prescribing physician certifies that the client's condition is stable; and

(b) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(3) When the department approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria in subsection (5) of this section.

(4) The department pays to maintain only the client's primary wheelchair, unless the conditions of subsection (6) of this section apply.

(5) The department pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients only when one of the following circumstances applies:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The department requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

(6) When the department approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the circumstances in subsection (5) of this section, the department pays to maintain both wheelchairs.

NEW SECTION

WAC 388-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs. (1) The department covers, with prior authorization, wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. To receive payment, providers must submit the following to the department:

(a) A completed General Information for Authorization form (DSHS 13-835). The department's electronic forms are available online (see WAC 388-543-7000 Authorization);

(b) A completed Prescription form (DSHS 13-794);

(c) A completed Medical Necessity for Wheelchair Purchase (for home clients only) form (DSHS 13-727). The date on this form (DSHS 13-727) must not be dated prior to the date on the Prescription form (DSHS-13-794);

(d) The make, model, and serial number of the wheelchair to be modified;

(e) The modification requested; and

(f) Any specific information regarding the client's medical condition that necessitates the modification.

(2) The department pays for transit option restraints only when used for client-owned vehicles.

(3) The department covers, with prior authorization, wheelchair repairs. To receive payment, providers must submit the following to the department:

(a) General Information for Authorization form (DSHS 13-835). The department's electronic forms are available online (see WAC 388-543-7000);

(b) A completed Medical Necessity for Wheelchair Purchase form (for home clients only) (DSHS 13-727);

(c) The make, model, and serial number of the wheelchair to be repaired; and

(d) The repair requested.

(4) Prior authorization is required for the repair and modification of client-owned equipment.

NEW SECTION

WAC 388-543-5000 Covered—Prosthetics/orthotics. (1) The department covers, without prior authorization, the following prosthetics and orthotics, with stated limitations:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(2) The department pays only licensed prosthetic and orthotic providers to supply prosthetics and orthotics. This requirement does not apply to the following:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out-of-state providers, who must meet the licensure requirements of that state.

(3) The department pays only for prosthetics or orthotics that are listed as such by the centers for medicare and medicaid services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and WAC 388-543-1200.

(4) The department pays for repair or modification of a client's current prosthesis. To receive payment, all of the following must be met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has supporting documentation; and

(c) The repair is warranted for a minimum of ninety days.

(5) The department requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, the department requires the client's caregiver to be responsible. The department requires prior authorization for extensive maintenance to a prosthetic or orthotic.

(6) For prosthetics dispensed for purely cosmetic reasons, see WAC 388-543-3800 Noncovered-DME.

NEW SECTION

WAC 388-543-5500 Covered—Medical supplies and related services. The department covers, without prior authorization, the following medical supplies and related services:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one pint per month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month;

(2) Bandages, dressings, and tapes;

(3) Batteries - replacement batteries:

(a) The department pays for the purchase of replacement batteries for wheelchairs.

(b) The department does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. See WAC 388-543-3400 for speech generating devices and chapter 388-548 WAC for ventilators.

(4) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three-month period;

(b) Spring-powered device for lancet - one in a six-month period;

(c) Diabetic test strips as follows:

(i) For clients, twenty years of age and younger, as follows:

(A) Insulin dependent, three hundred test strips and three hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, per month.

(ii) For clients, twenty-one years of age and older:

(A) Insulin dependent, one hundred test strips and one hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, every three months.

(iii) For pregnant women with gestational diabetes, the department pays for the quantity necessary to support testing as directed by the client's physician, up to sixty days postpartum.

(d) See WAC 388-543-5500(12) for blood glucose monitors.

(5) Braces, belts, and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(b) Ankle, elbow, or wrist brace - two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(6) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lamb's wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(7) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. The department does not pay for either of the following when billed in combination with an ostomy faceplate:

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(8) Syringes and needles;

(9) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a top sheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the back sheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a back sheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The department pays for urological products when they are used alone. The following are examples of products which the department does not pay for when used in combination with each other:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use. Example: pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

(h) Purchased disposable diapers (any size) are limited to two hundred per month for clients three years of age and older.

(i) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred per month.

(j) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a client age three to eighteen years of age; and

(ii) One hundred fifty per month for a client nineteen years of age and older.

(k) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(l) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(10) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - two per month. The department does not pay for these when billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The department does not pay for these when billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. The department does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. The department does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter, individual indwelling catheters, and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. The department does not pay for these when billed in combination with an insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston). The department does not pay for these when billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. The department does not pay for these when billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. The department does not pay for these when billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric), replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. The department does not pay for these when billed in combination with a latex urinary leg bag, urinary suspensory without leg bag, extension drainage tubing, or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. The department does not pay for these when billed in combination with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. The department does not pay for these when billed in combination with or without catheter.

(11) Miscellaneous supplies:

(a) Bilirubin light therapy supplies when provided with a bilirubin light which the department prior authorized - five days supply.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Nontoxic gel (e.g., LiceOff TM) for use with lice combs - one bottle per twelve-month period.

(f) Nonsterile gloves - two hundred, per client, per month.

(i) For clients residing in an assisted living facility, the department pays, with prior authorization, for additional nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of four hundred per client, per month.

(ii) Prior authorization requests must include a completed:

(A) General Information for Authorization form (DSHS 13-835). The department's electronic forms are available online (see WAC 388-543-7000 Authorization); and

(B) Limitation Extension Request Incontinent Supplies and Gloves form (DSHS 13-870).

(g) Sterile gloves - thirty pair, per client, per month.

(12) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period for at-home newborns with jaundice.

(b) Blood glucose monitor (specialized or home) - one in a three-year period. See WAC 388-543-5500(4) for blood monitoring/testing supplies. The department does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC 388-553-500 home infusion therapy/parenteral nutrition program.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(f) Pneumatic compressor - one in a five-year period.

(g) Positioning car seat - one in a five-year period.

NEW SECTION

WAC 388-543-5700 Covered—DME and related supplies for clients in skilled nursing facilities. (1) The department's skilled nursing facility per diem rate, established in chapter 74.46 RCW, chapter 388-96 WAC, and chapter 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this section.

(2) The department pays for the following covered DME and related supplies outside of the skilled nursing facility per diem rate, subject to the limitations in this section:

(a) Manual or power-drive wheelchairs;

(b) Speech generating devices (SGD); and

(c) Specialty beds.

(3) The department pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization, according to the requirements in WAC 388-543-4100, 388-543-4200, and 388-543-4300. Requests for prior authorization must:

(a) Be for the exclusive full-time use of a skilled nursing facility resident;

(b) Not be included in the skilled nursing facility's per diem rate;

(c) Include a completed General Information for Authorization form (DSHS 13-835);

(d) Include a copy of the telephone order, signed by the physician, for the wheelchair assessment;

(e) Include a completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (DSHS 13-729).

(4) The department pays for wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges, with prior authorization. To receive payment, providers must submit the following to the department:

(a) A completed Prescription form (DSHS 13-794);

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (DSHS 13-729). The date on this form (DSHS 13-727) must not be prior to the date on the Prescription form (DSHS-13-794). The department's electronic forms are available online (see WAC 388-543-7000 Authorization);

(c) The make, model, and serial number of the wheelchair to be modified;

(d) The modification requested; and

(e) Specific information regarding the client's medical condition that necessitates modification.

(5) The department pays for wheelchair repairs, with prior authorization. To receive payment, providers must submit the following to the department:

(a) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (DSHS 13-729). The department's electronic forms are available online (see WAC 388-543-7000 Authorization);

(b) The make, model, and serial number of the wheelchair to be repaired; and

(c) The repair requested.

(6) Prior authorization is required for the repair and modification of client-owned equipment.

(7) The skilled nursing facility must provide a house wheelchair as part of the per diem rate, when the client resides in a skilled nursing facility.

(8) When the client is eligible for both medicare and medicaid and is residing in a skilled nursing facility in lieu of hospitalization, the department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service (FFS).

(9) The department pays for the purchase and repair of a speech generating device (SGD), with prior authorization. The department pays for replacement batteries for SGDs in accordance with WAC 388-543-5500(3).

(10) The department pays for the purchase or rental of a specialty bed (a heavy duty bariatric bed is not a specialty bed), with prior authorization, when:

(a) The specialty bed is intended to help the client heal; and

(b) The client's nutrition and laboratory values are within normal limits.

(11) The department considers decubitus care products to be included in the skilled nursing facility per diem rate and does not reimburse for these separately.

(12) See WAC 388-543-9200 for reimbursement for wheelchairs.

(13) The department pays for the following medical supplies for a client in a skilled nursing facility outside the skilled nursing facility per diem rate:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning

internal body organ. This includes, but is not limited to the following:

(i) Colostomy and other ostomy bags and necessary supplies (see WAC 388-97-1060(3)); and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies.

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony.

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks post-surgery.

NEW SECTION

WAC 388-543-6000 DME and related supplies, medical supplies and related services—Noncovered. The department pays for DME and related supplies, medical supplies and related services only when listed as covered in this chapter. The department evaluates a request for any durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies listed as noncovered in this chapter under the provisions of WAC 388-501-0160. In addition to the noncovered services found in WAC 388-501-0070, the department does not cover:

(1) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by the department for the client contributes to an increased utility bill;

(2) Instructional materials such as pamphlets and video tapes;

(3) Hairpieces or wigs;

(4) Material or services covered under manufacturers' warranties;

(5) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(6) Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;

(7) Prosthetic devices dispensed for cosmetic reasons;

(8) Home improvements and structural modifications, including but not limited to the following:

(a) Automatic door openers for the house or garage;

(b) Electrical rewiring for any reason;

(c) Elevator systems and elevators;

(d) Installation of, or customization of existing, bathtubs or shower stalls;

(e) Lifts or ramps for the home;

(f) Overhead ceiling track lifts;

(g) Saunas;

(h) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(i) Swimming pools; and

(j) Whirlpool systems, such as jacuzzis, hot tubs, or spas.

(9) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(a) Back-packs, pouches, bags, baskets, or other carrying containers;

(b) Bedboards/conversion kits, and blanket lifters (e.g., for feet);

(c) Car seats for children seven years of age and younger or less than four feet nine inches tall, except for prior authorized positioning car seats under WAC 388-543-3200;

(d) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(e) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(f) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(i) Devices intended for amplifying voices (e.g., microphones);

(ii) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services;

(iii) Two-way radios;

(iv) Rental of related equipment or services; and

(v) Devices requested for the purpose of education.

(g) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads, and light boxes;

(h) Ergonomic equipment;

(i) Durable medical equipment that is used in a clinical setting;

(j) Exercise classes or equipment such as exercise mats, exercise balls, bicycles, tricycles, stair steppers, weights, or trampolines;

(k) Generators;

(l) Computer software other than speech generating software, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(m) Computer utility bills, telephone bills, internet service bills, or technical support for computers or electronic notebooks;

(n) Any communication device that is useful to someone without severe speech impairment (including but not limited to cellular telephone and associated hardware, walkie-talkie, two-way radio, pager, or electronic notebook);

(o) Racing strollers/wheelchairs and purely recreational equipment;

(p) Room fresheners/deodorizers;

(q) Bidet or hygiene systems, "sharps" containers, paraffin bath units, and shampoo rings;

(r) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(s) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(t) Wheeled reclining chairs, lounge and/or lift chairs (including but not limited to geri-chair, posture guard, or lazy boy).

(10) Blood pressure monitoring:

(a) Sphygmomanometer/blood pressure apparatus with cuff and stethoscope;

(b) Blood pressure cuff only; and

(c) Automatic blood pressure monitor.

(11) Transcutaneous electrical nerve stimulation (TENS) devices and supplies, including battery chargers;

(12) Functional electrical stimulation (FES) bike;

(13) Wearable defibrillators;

(14) Disinfectant spray;

(15) Periwash;

(16) Bathroom equipment used inside or outside of the physical space of a bathroom:

(a) Bath stools;

(b) Bathtub wall rail (grab bars);

(c) Bed pans;

(d) Bedside commode chair;

(e) Control unit for electronic bowel irrigation/evacuation system;

(f) Disposable pack for use with electronic bowel system;

(g) Potty chairs;

(h) Raised toilet seat;

(i) Safety equipment (including but not limited to belt, harness or vest);

(j) Shower chairs;

(k) Shower/commode chairs;

(l) Sitz type bath or equipment;

(m) Standard and heavy duty bath chairs;

(n) Toilet rail;

(o) Transfer bench for tub or toilet;

(p) Urinal male/female.

(17) Personal and/or comfort items, including but not limited to the following:

(a) Bathroom and hygiene items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(b) Bedding items, such as mattress pads, blankets, mattress covers/bags, pillows, pillow cases/covers, sheets, and bumper pads;

(c) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(d) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, socks, custom vascular supports (CVS), surgical stockings, gradient compression stockings, and custom compression garments and lumbar supports for pregnancy;

(e) Clothing protectors, surgical masks, and other protective cloth furniture coverings;

(f) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(g) Diverter valves and handheld showers for bathtub;

(h) Eating/feeding utensils;

(i) Emesis basins, enema bags, and diaper wipes;

(j) Health club memberships;

(k) Hot or cold temperature food and drink containers/holders;

(l) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(m) Impotence devices;

(n) Insect repellants;

(o) Massage equipment;

(p) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(q) Medicine cabinet and first-aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(r) Page turners;

(s) Radio and television;

(t) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services;

(u) Toothettes and toothbrushes, waterpics, and periodontal devices whether manual, battery-operated, or electric;

(18) Certain wheelchair features and options including, but not limited to, the following:

(a) Attendant controls (remote control devices);

(b) Canopies, including those used for strollers and other equipment;

(c) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(d) Decals;

(e) Hub Lock brake;

(f) Identification devices (such as labels, license plates, name plates);

(g) Lighting systems;

(h) Replacement key or extra key;

(i) Speed conversion kits; and

(j) Trays for clients in a skilled nursing facility.

(19) New durable medical equipment, supplies, or related technology that the department has not evaluated for coverage. See WAC 388-543-2100.

NEW SECTION

WAC 388-543-7000 Authorization. (1) The department requires providers to obtain authorization for covered durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related equipments as required in this chapter, chapters 388 501 and 388 502 WAC, and in published department billing instructions and/or numbered memoranda or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the department as specified in the department's published billing instructions (see WAC 388-543-7100). All requests for prior authorization must be accompanied by a completed General Information for Authorization form (DSHS 13-835) in addition to any program specific DSHS forms as required within this chapter. The department's electronic forms are available online at: http://www.dshs.wa.gov/msa/forms/eforms.html.

(b) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the department's published billing instructions. The appropriate EPA number must be used when the provider bills the department (see WAC 388-543-7200).

(2) When a service requires authorization, the provider must properly request authorization in accordance with the department's rules, billing instructions, and numbered memoranda.

(3) The department's authorization of service(s) does not necessarily guarantee payment.

(4) When authorization is not properly requested, the department rejects and returns the request to the provider for further action. The department does not consider the rejection of the request to be a denial of service.

(5) Authorization requirements in this chapter are not a denial of service to the client.

(6) The department may recoup any payment made to a provider if the department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388 502 0100 (1)(c).

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

NEW SECTION

WAC 388-543-7100 Prior authorization. (1) The department requires providers to obtain prior authorization for certain items and services before delivering that item or service to the client, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. The item or service must also be delivered to the client before the provider bills the department.

(2) All prior authorization requests must be accompanied by a completed General Information for Authorization form (DSHS 13-835), in addition to any program specific department forms as required within this chapter. Department forms are available online at http://www.dshs.wa.gov/msa/forms/eforms.html.

(3) When the department receives the initial request for prior authorization, the prescription(s) for those items or services must not be older than three months from the date the department receives the request.

(4) The department requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(5) For prior authorization requests, the department requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. The department does not accept general standards of care or industry standards for generalized equipment as justification.

(6) The department considers requests for new durable medical equipment (DME) and related supplies, prosthetics, orthotics, medical supplies and related equipments that do not have assigned healthcare common procedure coding system (HCPCS) codes and are not listed in the department's published issuances, including billing instructions or numbered memoranda. These items require prior authorization. The provider must furnish all of the following information to the department to establish medical necessity:

(a) A detailed description of the item(s) or service(s) to be provided;

(b) The cost or charge for the item(s);

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item(s) being provided; and

(d) A detailed explanation of how the requested item(s) differs from an already existing code description.

(7) The department does not pay for the purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the provider believes the purchase, rental, or repair of medical equipment is not duplicative, the provider must request prior authorization and submit the following to the department:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet the client's medical needs.

(c) Upon request, documentation showing how the client's condition met the criteria for PA or EPA.

(8) A provider may resubmit a request for prior authorization for an item or service that the department has denied. The department requires the provider to include new documentation that is relevant to the request.

NEW SECTION

WAC 388-543-7200 Limitation extension (LE). (1) The department limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization.

(2) Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

(3) The department requires a provider to request prior authorization for a limitation extension (LE) in order to exceed the stated limits for nondurable medical equipment and medical supplies. All requests for prior authorization must be accompanied by a completed General Information for Authorization form (DSHS 13-835) in addition to any program specific DSHS forms as required within this chapter. Department forms are available online at http://www.dshs.wa.gov/msa/forms/eforms.html.

(4) The department evaluates such requests for LE under the provisions of WAC 388-501-0169.

NEW SECTION

WAC 388-543-7300 Expedited prior authorization (EPA). (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes.

(2) The department requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in the department published DME-related billing instructions. The authorization number must be used when the provider bills the department.

(3) Upon request, a provider must provide documentation to the department showing how the client's condition met the criteria for EPA.

(4) A written or telephone request for prior authorization is required when a situation does not meet the EPA criteria for selected DME procedure codes.

(5) The department may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria.

NEW SECTION

WAC 388-543-8000 DME—Billing general. (1) A provider must not bill the department for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(2) The department does not pay a DME provider for medical supplies used in conjunction with a physician office visit. The department pays the office physician for these supplies when appropriate. Refer to the department's physician-related services billing instructions.

NEW SECTION

WAC 388-543-8100 DME—Billing for managed care clients. If a fee-for-service (FFS) client enrolls in a department-contracted managed care organization (MCO), the following apply:

(1) The department stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.

(2) The plan determines the client's continuing need for the equipment and is responsible for paying the provider.

(3) A client may become an MCO enrollee before the department completes the purchase of prescribed medical equipment. The department considers the purchase complete when the product is delivered and the department is notified of the serial number. If the client becomes an MCO enrollee before the department completes the purchase:

(a) The department rescinds the department's authorization with the vendor until the MCO's primary care provider (PCP) evaluates the client; then

(b) The department requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

(c) The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.

(4) A client may be disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment.

(a) The department rescinds the MCO's authorization with the vendor until the client's primary care provider (PCP) evaluates the client; then

(b) The department requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

(c) The department's applicable reimbursement policies apply to the purchase or rental of the equipment.

NEW SECTION

WAC 388-543-8200 DME—Billing for clients eligible for medicare and medicaid. If a client is eligible for both medicare and medicaid, the following apply:

(1) The department requires a provider to accept medicare assignment before any medicaid reimbursement;

(2) In accordance with WAC 388-502-0110(3):

(a) If the service provided is covered by medicare and medicaid, the department pays only the deductible and/or coinsurance up to medicare's or medicaid's allowed amount, whichever is less.

(b) If the service provided is covered by medicare but is not covered by the department, the department pays only the deductible and/or coinsurance up to medicare's allowed amount.

NEW SECTION

WAC 388-543-9000 DME and related supplies, prosthetics, orthotics, medical supplies and related services—General reimbursement. (1) The department pays qualified providers who meet all of the conditions in WAC 388-502-0100, for durable medical equipment (DME), supplies, repairs, and related services provided on a fee-for-service (FFS) basis as follows:

(a) To department-enrolled DME providers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and codes in the department's current DME billing instructions; and

(b) In accordance with the healthcare common procedure coding system (HCPCS) guidelines for product classification and code assignation.

(2) The department sets, evaluates, and updates the maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and related services at least once yearly using available published information, including but not limited to:

(a) Commercial databases;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

(3) The department may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the department determines that such actions are necessary.

(4) The department updates the maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and related services at least once per year, unless otherwise directed by the legislature or deemed necessary by the department.

(5) The department's maximum payment for DME and related supplies, prosthetics, orthotics, medical supplies and related services is the lesser of either of the following:

(a) Providers' usual and customary charges; or

(b) Established rates, except as provided in WAC 388-543-8200.

(6) The department is the payor of last resort for clients with medicare or third party insurance.

(7) The department does not pay for medical equipment and/or services provided to a client who is enrolled in a

department-contracted managed care plan, but who did not use one of the plan's participating providers.

(8) The department's reimbursement rate for purchased or rented covered DME and related supplies, prosthetics, orthotics, medical supplies and related services includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery or are covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up and/or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, and/or postage;

(e) Routine maintenance of DME that includes testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting and/or set-up; and

(g) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(9) DME, supplies, repairs, and related services supplied to eligible clients under the following reimbursement methodologies are included in those methodologies and are not reimbursed under fee-for-service:

(i) Hospice providers' per diem reimbursement;

(ii) Hospitals' diagnosis-related group (DRG) reimbursement;

(iii) Managed care plans' capitation rate;

(iv) Skilled nursing facilities' per diem rate; and

(v) Professional services' resource-based relative value system reimbursement (RBRVS) rate.

(10) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the equipment, and warranty period, available to the department upon request.

(11) The dispensing provider who furnishes the equipment, supply or device to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any equipment that the department considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The equipment, supply or device continues to be medically necessary.

(12) If the rental equipment, supply or device must be replaced during the warranty period, the department recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment, supply or device delivered to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The equipment, supply or device continues to be medically necessary.

(13) See WAC 388-543-9100, 388-543-9200, 388-543-9300, and 388-543-9400 for other reimbursement methodologies.

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

NEW SECTION

WAC 388-543-9100 Reimbursement method—Other DME. (1) The department sets, evaluates and updates the maximum allowable fees for purchased other durable medical equipment (DME) at least once yearly using one or more of the following:

(a) The current medicare rate, as established by the federal centers for medicare and medicaid services (CMS), for a new purchase if a medicare rate is available;

(b) A pricing cluster; or

(c) On a by-report basis.

(2) Establishing reimbursement rates for purchased other DME based on pricing clusters.

(a) A pricing cluster is based on a specific healthcare common procedure coding system (HCPCS) code.

(b) The department's pricing cluster is made up of all the brands/models for which the department obtains pricing information. However, the department may limit the number of brands/models included in the pricing cluster. The department considers all of the following when establishing the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Introduction, substitution or discontinuation of certain brands/models; and/or

(iv) Cost.

(c) When establishing the fee for other DME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices for all brands/models as noted in subsection (2)(b) of this section.

(3) The department evaluates a by report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The department calculates the reimbursement rate for these items at eighty-five percent of the manufacturer's list price.

(4) Monthly rental reimbursement rates for other DME. The department's maximum allowable fee for monthly rental is established using one of the following:

(a) For items with a monthly rental rate on the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the department equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;

(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the department sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the department considers the maximum allowable monthly reimbursement rate as by-report. The department calculates the monthly reimbursement rate for these items at one-tenth of eighty-five percent of the manufacturer's list price.

(5) Daily rental reimbursement rates for other DME. The department's maximum allowable fee for daily rental is established using one of the following:

(a) For items with a daily rental rate on the current medicare fee schedule as established by the centers for medicare and medicaid services (CMS), the department equates its maximum allowable fee for daily rental to the current medicare daily rental rate;

(b) For items that have a new purchase rate but no daily rental rate on the current medicare fee schedule as established by CMS, the department sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by CMS, the department considers the maximum allowable daily reimbursement rate as by-report. The department calculates the daily reimbursement rate at one-three-hundredth of eighty-five percent of the manufacturer's list price.

(6) The department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both medicare and medicaid, and is staying in a skilled nursing facility in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(7) The department rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(8) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the department may pay the provider an amount it considers appropriate to help defray these extra costs. The department requires the provider to submit justification sufficient to support such a claim.

NEW SECTION

WAC 388-543-9200 Reimbursement method—Wheelchairs. (1) The department reimburses a DME provider for purchased wheelchairs based on the specific brand and model of wheelchair dispensed. The department decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) A client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) The department sets, evaluates and updates the maximum allowable fees at least once yearly for wheelchair purchases, wheelchair rentals, and wheelchair accessories (e.g., cushions and backs) using the lesser of the following:

(a) The current medicare fees;

(b) The actual invoice for the specific item; or

(c) A percentage of the manufacturer's list price. The department uses the following percentages:

(i) For basic standard wheelchairs, sixty-five percent;

(ii) For add-on accessories and parts, eighty-four percent;

(iii) For up-charge modifications and cushions, eighty percent;

(iv) For all other manual wheelchairs, eighty percent; and

(v) For all other power-drive wheelchairs, eighty-five percent.

NEW SECTION

WAC 388-543-9300 Reimbursement method—Prosthetics and orthotics. (1) The department sets, evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once yearly as follows:

(a) For items with a rate on the current medicare fee schedule, as established by the federal centers for medicare and medicaid services (CMS), the department equates its maximum allowable fee to the current medicare rate; and

(b) For those items not included in the medicare fee schedule, as established by CMS, the rate is considered by-report. The department evaluates a by-report item, procedure, or service based upon medical necessity criteria, appropriateness, and reimbursement value on a case-by-case basis. The department calculates the reimbursement for these items at eighty-five percent of the manufacturer's list price.

(2) The department follows healthcare common procedure coding system (HCPCS) guidelines for product classification and code assignation.

(3) The department's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds, fitting, shipping, handling or any other administrative expenses related to provision of the prosthetic or orthotic to the client.

(4) The department's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

NEW SECTION

WAC 388-543-9400 Reimbursement method—Medical supplies and related services. (1) The department sets, evaluates and updates the maximum allowable fees for medical supplies and nondurable medical equipment (DME) items at least once yearly using one or more of the following:

(a) The current medicare rate, as established by the federal centers for medicare and medicaid services (CMS), if a medicare rate is available;

(b) A pricing cluster;

(c) Based on input from stakeholders or other relevant sources that the department determines to be reliable and appropriate; or

(d) On a by-report basis.

(2) Establishing reimbursement rates for medical supplies and non-DME items based on pricing clusters.

(a) A pricing cluster is based on a specific healthcare common procedure coding system (HCPCS) code.

(b) The department's pricing cluster is made up of all the brands for which the department obtains pricing information.

However, the department may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the department. The department considers all of the following when establishing the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Cost; and

(iv) Available alternatives.

(c) When establishing the fee for medical supplies or other nonDME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices.

(3) The department evaluates a by report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The department calculates the reimbursement rate at eighty-five percent of the manufacturer's list price.

(4) For clients residing in skilled nursing facilities, see WAC 388-543-5700.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-543-1150	Limits and limitation extensions.
WAC 388-543-1200	Providers who are eligible to provide services.
WAC 388-543-1225	Provider requirements.
WAC 388-543-1300	Equipment, related supplies, or other nonmedical supplies, and devices that are not covered.
WAC 388-543-1400	General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services.
WAC 388-543-1500	When MAA purchases DME and related supplies, prosthetics, and orthotics.
WAC 388-543-1600	Items and services which require prior authorization.
WAC 388-543-1700	When the department covers rented DME.
WAC 388-543-1800	Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services.
WAC 388-543-1900	Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services.
WAC 388-543-2400	Hospital beds.
WAC 388-543-2500	Reimbursement methodology for other durable medical equipment.
WAC 388-543-2600	Prosthetics and orthotics.
WAC 388-543-2700	Prosthetics and orthotics—Reimbursement.
WAC 388-543-2800	Reusable and disposable medical supplies.
WAC 388-543-2900	Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.

WSR 11-15-023
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

[Filed July 8, 2011, 1:13 p.m., effective August 8, 2011]

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

Purpose: DSHS is updating WACs to change the deeming and allocation rules for SSI-related medical programs so they mirror the federal rules. The department is creating new WACs to further clarify deeming rules relating to deeming from ineligible parents to applicant children; deeming between an applicant spouse and a nonapplying spouse; and deeming between spouses when one spouse is institutionalized. DSHS is adding new language in WAC 388-475-0840 to support the student earned income exclusion and adding language in WAC 388-475-0820 to define a student for SSI-related medical. DSHS is repealing WAC 388-506-0620 and incorporating the language to a new rule in the chapter 388-475 WAC series.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-506-0620; amending WAC 388-475-0820, 388-475-0840, and 388-475-0900.

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

Adopted under notice filed as WSR 11-11-084 on May 18, 2011.

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 3, Amended 3, Repealed 1.

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 3, Amended 3, Repealed 1.

Date Adopted: July 8, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-04-046, filed 1/26/06, effective 2/26/06)

WAC 388-475-0820 SSI-related medical—Child-related income exclusions and allocations. (1) ((~~The department excludes an allowance from a person's earned and/or unearned income for a child living in the home when~~)) For the purposes of SSI-related medical eligibility determinations under chapter 388-475 WAC, a child is defined as an individual who is:

(a) ((~~The minor child lives with an SSI-related parent~~)) Unmarried; ((~~and~~))

(b) ((~~The minor child is not receiving a needs-based cash payment such as TANF or SSI~~)) Living in the household of the SSI-related applicant; ((~~and~~))

(c) ((~~The SSI-related parent is single~~)) The natural, adopted or stepchild of the SSI-related applicant or the applicant's spouse; ((~~or~~))

(d) ((~~The SSI-related parent lives with a spouse who has no income; and~~)) Not receiving a needs-based cash payment such as TANF or SSI; and

(e) ((~~The individual applying for or receiving SSI-related medical benefits is the adult parent. The maximum allowance is one-half the Federal Benefit Rate (FBR) for each child.~~)) Is either:

(i) Age seventeen or younger; or

(ii) Age twenty-one or younger and meets the SSI-related definition of a student described in subsection (6) of this section.

(2) The department allows an allocation for the support of a child when determining the countable income of an SSI-related applicant. The allocation is calculated as follows:

(a) For categorically needy (CN) medical coverage, the allocation is deducted from the countable income of a nonapplying spouse before determining the amount of the nonapplying spouse's income to be deemed to the SSI-related applicant. Allocations to children are not deducted from the income of an unmarried SSI-related applicant.

(b) For medically needy (MN) medical coverage, the allocation is first deducted from the income of the nonapplying spouse as described in subsection (2)(a) of this section when the SSI-related applicant is married, and from the income of the applicant when the applicant is not married.

(3) The child's countable income, if any, is subtracted from the maximum child's allowance before determining ((~~this allowance~~)) the amount of allocation.

(((~~2~~))) (4) Foster care payments received for a child who is not SSI-eligible and who is living in the household, placed there by a licensed, nonprofit or public child placement or childcare agency are excluded from income regardless of whether the person requesting or receiving SSI-related medical is the adult foster parent or the child who was placed.

(((~~3~~))) (5) Adoption support payments, received by an adult for a child in the household that are designated for the child's needs, are excluded as income. Adoption support payments that are not specifically designated for the child's needs are not excluded and are considered unearned income to the adult.

(((~~4~~))) (6) The department excludes the earned income of a person ((~~under age twenty-two is excluded~~)) age twenty-one or younger if that person is a student. A student must meet one of the following criteria in order to allow the student earned income exclusion:

(a) Attend a school, college, or university a minimum of eight hours a week; or

(b) Pursue a vocational or technical training program designed to prepare the student for gainful employment a minimum of twelve hours per week; or

(c) Attend school or be home schooled in grades seven through twelve at least twelve hours per week.

(((~~5) Child support payments received from an absent parent for a child living in the home are considered the income of the child.~~

(~~6~~))) (7) Any portion of a grant, scholarship, fellowship, or gift used for tuition, fees and/or other necessary educational expenses at any educational institution is excluded from income and not counted as a resource for nine months after the month of receipt.

(8) One-third of child support payments received for a child ((~~are~~)) who is an applicant for SSI-related medical is excluded from the child's income. Child support payments that are subject to the one-third deduction may be voluntary or court-ordered payments for current support or arrears.

(((~~7) Any portion of a grant, scholarship, fellowship, or gift used for tuition, fees and/or other necessary educational expenses at any educational institution is excluded from income for nine months after the month of receipt.~~

(~~8~~))) (9) The one-third deduction described in subsection (8) of this section does not apply to child support payments received from an absent parent for a child living in the home when the parent(s) or their spouse is the applicant for SSI-related medical. Voluntary or court-ordered payments for current support or arrears are always considered the income of the child for whom they are intended and not income to the parent(s).

(10) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that code, is excluded as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(((~~9~~))) (11) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children are excluded from income. Any portion of a veteran's payment that is designed as the dependent's income is countable income to the dependent and not the applicant (assuming the applicant is not the dependent).

(((~~(10) Unless it is specifically contributed to the client, all earned income of an ineligible or nonapplying person under the age of twenty-one who is a student:~~

~~(a) Attending a school, college, or university; or~~

~~(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.~~))

AMENDATORY SECTION (Amending WSR 04-09-005, filed 4/7/04, effective 6/1/04)

WAC 388-475-0840 SSI-related medical—Work- and agency-related income exclusions. The department excludes the following when determining eligibility for SSI-related medical programs:

(1) Work related expenses:

(a) ((~~including child care,~~)) That enable an SSI-related client to work;

(b) That allows a blind or disabled client to work and that are directly related to the person's impairment.

(2) First sixty-five dollars plus one-half of the remainder of earned income. This is considered a work allowance/incentive. This deduction does not apply to income already excluded.

(3) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS).

(4) Earned income of a person age twenty-one or younger if that person meets the definition of a student as defined in WAC 388-475-0820.

(5) Veteran's Aid and Attendance, housebound allowance, unusual/unreimbursed medical expenses (UME) paid by the VA to some disabled veterans, their spouses, widows or parents. For people receiving long-term care services, see chapter 388-513 WAC.

(((~~(5)~~))) (6) Department of Veterans Affairs benefits designated for the veteran's dependent as long as the SSI-related applicant is not the dependent receiving the income. If an SSI-related applicant receives a dependent allowance based on the veteran's or veteran's survivor claim, the income is countable as long as it is not paid due to unusual medical expenses (UME).

(7) Payments provided in cash or in-kind, to an ineligible or nonapplying spouse, under any government program that provides social services provided to the client, such as chore services or attendant care.

(((~~(6)~~))) (8) SSA refunds for medicare buy-in premiums paid by the client when the state also paid the premiums.

(((~~(7)~~))) (9) Income that causes a client to lose SSI eligibility, due solely to reduction in the SSP.

(((~~(8) Department of Veteran's Affairs benefits designated for the veteran's dependent. It is considered income of that dependent.~~

~~(9)~~))) (10) Tax rebates or special payments excluded under other statutes.

(((~~(10)~~))) (11) Any public agency refund of taxes paid on real property or on food.

AMENDATORY SECTION (Amending WSR 04-09-005, filed 4/7/04, effective 6/1/04)

WAC 388-475-0900 SSI-related medical—((~~Allocating~~)) Deeming and allocation of income. The department considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) ((~~When income is allocated from an SSI-related person to other household members, that income is considered as the other members' income.~~

~~(2) A portion of the income of a spouse or parent is allocated to the needs of an SSI-related applicant when the spouse or parent is:~~

~~(a) Financially responsible for the SSI-related person as described in WAC 388-408-0055 and 388-506-0620. For long-term care programs, see WAC 388-513-1315, 388-513-1330, 388-513-1350; for waiver programs see WAC 388-515-1505 through 388-515-1530;~~

~~(b) Living in the same household;~~

~~(c) Not receiving SSI; and~~

~~(d) Either not related to SSI or is not applying for medical assistance.~~

~~(3) Allocations to children are deducted from the nonapplying spouse's unearned income, then from their earned income, before they are deducted from the applicant's income. See WAC 388-475-0820.~~

~~(4) If the conditions in subsection (2) are met, the income to be allocated from a parent to an SSI-related minor child applying for medical benefits is the amount remaining after deducting:~~

~~(a) All allowable income exclusions and disregards as described in WAC 388-475-750 through 388-475-880;~~

~~(b) One-half of the federal benefit rate (FBR) for each SSI ineligible sibling of the SSI related child living in the household, minus any countable income of that child. See WAC 388-478-0055 for FBR amount;~~

~~(c) The parent's allowance, either the one person FBR for a single parent or two person FBR for a two-parent household.~~

~~(5) A portion of the countable income of a nonapplying spouse remaining after the deductions in subsection (4) may be allocated to the SSI-related spouse as follows for CN medical determinations:~~

~~(a) If the income is less than or equal to one-half of the FBR after allowing the income exclusions in subsection (4) of this section, no income is allocated to the client.~~

~~(b) If the income is equal to or more than one-half of the FBR after allowing the income exclusions in subsection (4) of this section, all income other than the excluded amounts is allocated to the applying spouse.~~

~~(6) Deductions from the income of the nonapplying spouse of an SSI-related applicant for CN medical determinations are:~~

~~(a) Income exclusions as described in WAC 388-475-0750 through 388-478-0880;~~

~~(b) One-half of the federal benefit rate (FBR) as described in WAC 388-478-0055 for each eligible child in the household, minus the child's countable income.~~

~~(7) In determining MN medical eligibility for SSI-related applicants:~~

~~(a) If the income of the nonapplying spouse is less than the MNIL (see WAC 388-478-0070) after applying any child allocation, a portion of the applying spouse's countable income is added to the nonapplying spouse's income to raise it to the MNIL for MN;~~

~~(b) If the income of the nonapplying spouse is more than the MNIL after applying any child allocation, the entire amount exceeding the MNIL is allocated to the applying spouse.~~

~~(8)~~)) Deeming is the process of determining how much of another person's income is counted when determining eligibility of an SSI-related applicant. When income is deemed to the SSI-related applicant from other household members, that income is considered the applicant's income. Income is deemed only:

(a) From a nonapplying spouse who lives with the SSI-related applicant; or

(b) From a parent(s) residing with an SSI-related applicant child.

(2) An allocation is an amount deducted from income counted in the eligibility determination and considered to be set aside for the support of a person other than the SSI-related applicant. When income is allocated to other household members from the SSI-related applicant(s) or from the applicant's spouse, that income is not counted as income of the SSI applicant.

(3) An SSI-related person applying for categorically needy (CN) medical coverage must have countable income at or below the SSI categorically needy income level (CNIL) described in WAC 388-478-0080 unless the person is working and meets all requirements for the healthcare for workers with disabilities (HWD) program described in WAC 388-475-1000 through 388-475-1250.

(4) For institutional or home and community based waiver programs, use rules described in WAC 388-513-1315.

(5) The department follows rules described in WAC 388-475-0600 through 388-475-0880 to determine the countable income of an SSI-related applicant or SSI-related couple.

(6) If countable income of the applicant exceeds the one-person SSI CNIL prior to considering the income of a nonapplying spouse or children, the applicant is not eligible for CN medical coverage and the department determines eligibility for the medically needy (MN) program. If the countable income does not exceed the SSI CNIL, see WAC 388-475-0920 to determine if income is to be deemed to the applicant from the nonapplying spouse.

(7) If countable income (after allowable deductions) of an SSI-related couple both applying for medical coverage exceeds the two-person SSI CNIL, the couple is not eligible for CN medical coverage and the department determines eligibility for the medically needy (MN) program.

(8) For CN medical coverage, allocations to children are deducted from the nonapplying spouse's unearned income, then from their earned income before income is deemed to the SSI-related applicant. See WAC 388-475-0820.

(9) For MN medical coverage, allocations to children are deducted from the income of the SSI-related applicant or SSI-related applicant couple. See subsection (10) of this section to determine the amount of the allocation.

(10) An SSI-related individual or couple applying for MN medical coverage is allowed an allocation to a nonapplying spouse, their SSI recipient spouse or their dependent child(ren) to reduce countable income before comparing income to the medically needy income level (MNIL) described in WAC 388-478-0070. The department allocates income:

(a) Up to the one-person MNIL to a nonapplying spouse or SSI recipient spouse minus the spouse's countable income; and

(b) Up to one-half of the federal benefit rate (FBR) to each dependent minus each dependent's countable income. See WAC 388-475-0820 for child exclusions.

(11) A portion of a nonapplying spouse's income may be deemed to the SSI-related applicant:

(a) See WAC 388-475-0920(5) to determine how much income is deemed from a nonapplying spouse to the SSI-related applicant when determining CN eligibility; and

(b) See WAC 388-475-0920(10) to determine how much income is deemed from a nonapplying spouse to the SSI-related applicant when determining MN eligibility.

(12) A portion of the income of an ineligible parent or parents is allocated to the needs of an SSI-related applicant child. See WAC 388-475-0940 (4) through (7) to determine how much income is allocated from ineligible parent(s).

(13) Only income and resources actually contributed to an alien applicant from their sponsor are counted as income. For allocation of income from an alien sponsor, refer to WAC 388-450-0155.

NEW SECTION

WAC 388-475-0920 SSI-related medical—Deeming/allocation of income from nonapplying spouse. The department considers the income of financially responsible persons to determine if a portion of that income is available to other household members.

(1) A portion of the income of a nonapplying spouse is considered available to meet the needs of an SSI-related applicant. A nonapplying spouse is defined as someone who is:

(a) Financially responsible for the SSI-related applicant as described in WAC 388-408-0055 and 388-475-0960. For institutional and home and community based waiver programs, see WAC 388-513-1315;

(b) Living in the same household with the SSI-related applicant;

(c) Not receiving a needs based payment such as temporary assistance to needy families (TANF), state funded cash assistance (SFA); or

(d) Not related to SSI, or is not applying for medical assistance including spouses receiving SSI.

(2) An ineligible spouse is the spouse of an SSI cash recipient and is either not eligible for SSI for themselves or who has elected to not receive SSI cash so that their spouse may be eligible. An SSI-related applicant who is the ineligible spouse of an SSI cash recipient is not eligible for categorically needy (CN) medical coverage and must be considered for medical coverage under the medically needy (MN) program.

(3) When determining whether a nonapplying spouse's income is countable, the department:

(a) Follows the income rules described in WAC 388-475-0600 through 388-475-0750;

(b) Excludes income described in WAC 388-475-0800(2) through (11), and all income excluded under federal statute or state law as described in WAC 388-475-0860.

(c) Excludes work-related expenses described in WAC 388-475-0840, with the exception that the sixty-five dollars plus one half earned income deduction described in WAC 388-475-0840(2) does not apply;

(d) Deducts any court ordered child support which the nonapplying spouse pays for a child outside of the home (current support or arrears); and

(e) Deducts any applicable child-related income exclusions described in WAC 388-475-0820.

(4) The department allocates income of the nonapplying spouse to nonapplying children who reside in the home as described in WAC 388-475-0820. Allocations to children are deducted first from the nonapplying spouse's unearned income, then from their earned income.

(a) For CN medical determinations, allocations to children are not allowed out of the income of the SSI-related applicant, only from the income of the nonapplying spouse.

(b) For MN medical determinations, allocations to children are allowed from the income of the SSI-related applicant if the applicant is unmarried.

(5) For SSI-related CN medical determinations, a portion of the countable income of a nonapplying spouse remaining after the deductions and allocations described in subsections (3) and (4) of this section may be deemed to the SSI-related applicant. If the nonapplying spouse's countable income is:

(a) Less than or equal to one-half of the federal benefit rate (FBR), no income is deemed to the applicant. Compare the applicant's countable income to the one-person SSI categorically needy income level (CNIL) described in WAC 388-470-0040. For healthcare for workers with disabilities (HWD) applicants, compare to the one-person HWD standard described in WAC 388-478-0075 (1)(c).

(b) Greater than one-half of the FBR, then the entire nonapplying spouse's countable income is deemed to the applicant. Compare the applicant's income to the two-person SSI CNIL. For HWD applicants, compare to the two-person HWD standard described in WAC 388-478-0075 (1)(c).

(6) When income is not deemed to the SSI-related applicant from the nonapplying spouse per section (5)(a):

(a) Allow all allowable income deductions and exclusions as described in chapter 388-475 WAC to the SSI-related applicant's income; and

(b) Compare the net remaining income to the one-person SSI CNIL or the one-person HWD standard.

(7) When income is deemed to the SSI-related applicant from the nonapplying spouse per subsection (5)(b) of this section:

(a) Combine the applicant's unearned income with any unearned income deemed from the nonapplying spouse and allow one twenty dollar general income exclusion to the combined amount.

(b) Combine the applicant's earned income with any earned income deemed from the nonapplying spouse and allow the sixty-five dollar plus one half of the remainder earned income deduction (described in WAC 388-475-0840(2)) to the combined amount.

(c) Add together the net unearned and net earned income amounts and compare the total to the two-person SSI CNIL or the two-person HWD standard described in WAC 388-478-0075 (1)(c). If the income is equal to or below the applicable two-person standard, the applicant is eligible for CN medical coverage.

(8) An SSI-related applicant under the age of sixty-five who is working at or below the substantial gainful activity (SGA) level but who is not eligible for CN coverage under the regular SSI-related program, may be considered for eligibility under the MN program or under the HWD program. The SGA level is determined annually by the Social Security Administration and is posted at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501015.

(9) If the SSI-related applicant's countable income is above the applicable SSI CNIL standard, the department considers eligibility under the MN program or under the HWD program if the individual is under the age of sixty-five and working. An SSI-related applicant who meets the following criteria is not eligible for MN coverage and eligibility must be determined under HWD:

(a) A blind or disabled individual who is under the age of sixty-five;

(b) Who has earned income over the SGA level; and

(c) Is not receiving a Title II social security cash benefit based on blindness or disability.

(10) For SSI-related MN medical determinations, a portion of the countable income of a nonapplying spouse remaining after the deductions and allocations described in subsections (3) and (4) of this section may be deemed to the SSI-related applicant. If the nonapplying spouse's countable income is:

(a) Less than or equal to the one person MNIL described in WAC 388-478-0070, no income is deemed to the applicant and a portion of the applicant's countable income is allocated to the nonapplying spouse's income to raise it to the MNIL.

(b) Greater than the MNIL, then the amount in excess of the one-person MNIL is deemed to the applicant. Compare the applicant's income to the one-person MNIL.

(11) When income is not deemed to the SSI-related applicant from the nonapplying spouse per subsection (10)(a) of this section:

(a) Allocate income from the applicant to bring the income of the nonapplying spouse up to the one-person MNIL standard;

(b) Allow all allowable income deductions and exclusions as described in chapter 388-475 WAC to the SSI-related applicant's remaining income;

(c) Allow a deduction for medical insurance premium expenses (if applicable); and

(d) Compare the net countable income to the one-person MNIL.

(12) When income is deemed to the SSI-related applicant from the nonapplying spouse per subsection (10)(b) of this section:

(a) Combine the applicant's unearned income with any unearned income deemed from the nonapplying spouse and

allow one twenty dollar general income exclusion to the combined amount;

(b) Combine the applicant's earned income with any earned income deemed from the nonapplying spouse and allow the sixty-five dollar plus one half of the remainder earned income deduction (described in WAC 388-475-0840(2)) to the combined amount;

(c) Add together the net unearned and net earned income amounts;

(d) Allow a deduction for medical insurance premium expenses (if applicable) per WAC 388-519-0100(5); and

(e) Compare the net countable income to the one-person MNIL described in WAC 388-478-0070. If the income is:

(i) Equal to or below the one-person MNIL, the applicant is eligible for MN medical coverage with no spenddown.

(ii) Greater than the MNIL, the applicant is only eligible for MN medical coverage after meeting a spenddown liability as described in WAC 388-519-0110.

(13) The ineligible spouse of an SSI-cash recipient applying for MN coverage is eligible to receive the deductions and allocations described in subsection (10)(a) of this section.

NEW SECTION

WAC 388-475-0940 SSI-related medical—Deeming income from an ineligible parent(s) to a child applying for SSI-related medical. The department considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) A portion of the income of a parent(s) is considered available to the SSI-related applicant child when the child is age seventeen or younger and the parent(s) is:

(a) Financially responsible for the SSI-related child as described in WAC 388-408-0055(2);

(b) The natural, adoptive, or step-parent of the child;

(c) Living in the same household with the child;

(d) Not receiving a needs-based payment such as TANF, SFA or SSI; and

(e) Not related to SSI or not applying for medical assistance.

(2) If an SSI-related applicant between the ages of eighteen to twenty-one lives with their parents, only consider the parent's income available to the applicant if it is actually contributed to the applicant. If income is not contributed, count only the applicant's own separate income.

(3) Income that is deemed to the child is considered as that child's income.

(4) When determining whether a parent's income is countable, the department follows:

(a) The income rules described in WAC 388-475-0600 through 388-475-0750; and

(b) Excludes income described in WAC 388-475-0800 and WAC 388-475-0840, and all income excluded under a federal statute or state law as described in WAC 388-475-0860.

(5) When determining the amount of income to be deemed from a parent(s) to an SSI-related minor child for categorically needy (CN) and medically needy (MN) coverage, the department reduces the parent(s) countable income in the following order:

(a) Court ordered child support paid out for a child not in the home;

(b) An amount equal to one half of the federal benefit rate (FBR) for each SSI-eligible sibling living in the household, minus any countable income of that child. See WAC 388-478-0055 for FBR amount;

(c) A twenty dollar general income exclusion;

(d) A deduction equal to sixty-five dollars plus one-half of the remainder from any remaining earned income of the parent(s);

(e) An amount equal to the one-person SSI CNIL for a single parent or the two-person SSI CNIL for a two parent household;

(f) Any income remaining after these deductions is considered countable income to the SSI-related child and is added to the child's own income. If there is more than one child applying for SSI-related medical coverage, the deemed parental income is divided equally between the applicant children; and

(g) The deductions described in this section are deducted first from unearned income then from earned income unless they are specific to earned income.

(6) The SSI-related applicant child is also allowed all applicable income exclusions and disregards described in chapter 388-475 WAC from their own income. After determining the child's nonexcluded income, the department:

(a) Allows the twenty dollar general income exclusion from any unearned income;

(b) Deducts sixty-five dollars plus one half of the remainder from any earned income which has not already been excluded under the student earned income exclusion (see WAC 388-475-0820).

(c) Adds the child's countable income to the amount deemed from their parent(s). If the combination of the child's countable income plus deemed parental income is equal to or less than the SSI CNIL, the child is eligible for SSI-related CN medical coverage.

(7) If the combination of the child's countable income plus deemed parental income is greater than the SSI CNIL, the department considers the child for SSI-related medically needy (MN) coverage. Any amount exceeding the medically needy income level (MNIL) is used to calculate the amount of the child's spenddown liability as described in WAC 388-519-0110. See WAC 388-478-0070 for the current MNIL standards.

NEW SECTION

WAC 388-475-0960 SSI-related medical—Allocating income—How the department considers income and resources when determining eligibility for an individual applying for noninstitutional medicaid when another household member is receiving institutional medicaid. (1) The department follows rules described in WAC 388-513-1315 for an individual residing in a medical institution, approved for a home and community based waiver, or approved for the institutional hospice program. The rules in this section describe how the department considers household

income and resources when the household contains both institutional and noninstitutionalized household members.

(2) An institutionalized individual (adult or child) who is not SSI-related may be considered under the long-term care for families and children programs described in WAC 388-505-0230 through 388-505-0265.

(3) The department considers the income and resources of spouses as available to each other through the end of the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(4) The department considers income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a boarding home (assisted living, enhanced adult residential center, adult residential center), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disabilities-group home (DDD-GH) facility when:

(a) Only one spouse enters the facility;

(b) Both spouses enter the same facility but have separate rooms; or

(c) Both spouses enter separate facilities.

(5) The department considers income and resources jointly when both spouses are placed in a boarding home, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(6) When determining SSI-related categorically needy (CN) or medically needy (MN) eligibility for a community spouse applying for medical coverage, the department counts:

(a) The separate income of the community spouse; plus

(b) One half of any community income received by the community spouse and the institutionalized spouse; plus

(c) Any amount allocated to the community spouse from the institutionalized spouse. The terms "community spouse" and "institutional spouse" are defined in WAC 388-513-1301.

(7) For the purposes of determining the countable income of a community spouse applying for medical coverage as described in subsection (6) above, it does not matter whether the spouses reside together or not. Income that is allocated and actually available to a community spouse is considered that person's income.

(8) For the purposes of determining the countable income of a community spouse or children applying for medical coverage under family, pregnancy or children's medical programs, the department uses the following rules to determine if the income of the institutionalized person is considered in the eligibility calculation:

(a) When the institutionalized spouse or parent lives in the same home with the community spouse and/or children, their income is counted in the determination of household income following the rules for the medical program that is being considered.

(b) When the institutionalized spouse or parent does not live in the same home as the spouse and/or children, only income that is allocated and available to the household is counted.

(9) When determining the countable income of a community spouse applying for medical coverage under the MN program, the department allocates income from the community spouse to the institutionalized spouse in an amount up to the one-person medically needy income level (MNIL) less the institutionalized spouse's income, when:

(a) The community spouse is living in the same household as the institutionalized spouse; and

(b) The institutionalized spouse is receiving home and community-based waiver or institutional hospice services described in WAC 388-515-1505; and

(c) The institutionalized spouse has gross income of less than the MNIL.

(10) See WAC 388-408-0055 for rules on how to determine medical assistance units for households that include SSI-related persons. A separate medical assistance unit is always established for individuals who meet institutional status described in WAC 388-513-1320.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-506-0620	SSI-related medical clients.

WSR 11-15-029
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed July 12, 2011, 8:29 a.m., effective August 12, 2011]

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

Purpose: These amendments reorganize the sections for nonemergency medical transportation; add/remove/update definitions; update client eligibility and responsibility; include a section on "covered trips"; add a new section for "exclusions and limitations"; include a section for "intermediate stops or delays"; add new section regarding local provider and trips outside the client's local community; update the section regarding meals/lodging/escort/guardian; expand the reimbursement section to clarify when reimbursement for preauthorized expenditures for trips, meals, and lodging must be requested, what documentation is required for reimbursement of mileage, fuel/gas, parking, bridge tolls, etc., and when the broker may retroactively authorize and reimburse transportation costs (including meals and lodging).

Citation of Existing Rules Affected by this Order: Amending WAC 388-546-5000, 388-546-5100, 388-546-5200, 388-546-5300, 388-546-5400, and 388-546-5500.

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

Other Authority: RCW 74.08.090.

Adopted under notice filed as WSR 11-10-070 on May 3, 2011.

Changes Other than Editing from Proposed to Adopted Version: **WAC 388-546-5100 Definitions,** added the fol-

lowing text to the proposed definition of "noncompliance or noncompliant":

"Noncompliance or noncompliant" - When a client:

- Fails to appear at the pick-up point of the trip at the scheduled pick-up time without good cause or without reasonable notification to the broker;
- Fails without good cause to comply with the rules, procedures, and/or policies of the department and/or those of the department's transportation brokers, the brokers' subcontracted transportation providers, and healthcare service providers;

WAC 388-546-5500 Covered trips.

Subsection (1)(a), changed "services is" to "services are."

Subsection (1)(d), changed "the" to "a."

Subsection (1)(g), corrected the reference to "WAC 388-546-6200(7) not (6)."

WAC 388-546-5700 Local provider and trips outside client's local community.

Subsection (3)(a)(ii), changed "locally" to "in the client's local community" for consistency.

Subsection (3)(b)(iii), the text was changed as follows:

Ongoing treatment of ~~the following~~ medical conditions that may qualify for transportation based on continuity of care, include but are not limited to:

(A) Active cancer treatment;

(B) Recent transplant (within the last twelve months);

(C) Scheduled surgery (within the next sixty days);

(D) Major surgery (within the previous sixty days); or

(E) Third trimester of pregnancy.

WAC 388-546-6200 Reimbursement.

Subsection (7)(b), the department added subsection (iii) with the following language which:

The trip involves an area that the department's broker considers to be unsafe for the client, other riders, or the driver.

A final cost-benefit analysis is available by contacting Walter Neal, P.O. Box 45530, Olympia, WA 98504-5530, phone (360) 725-1703, fax (360) 586-9727, e-mail Nealw@dshs.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 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 8, Amended 6, 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 8, Amended 6, Repealed 0.

Date Adopted: July 12, 2011.

Susan N. Dreyfus
Secretary

AMENDATORY SECTION (Amending WSR 01-06-029, filed 3/2/01, effective 4/2/01)

WAC 388-546-5000 Nonemergency transportation ((~~program definitions~~)) —General. ((~~The following terms apply to WAC 388-546-5000, 388-546-5100, 388-546-5200, 388-546-5300, 388-546-5400, and 388-546-5500:~~

~~**"Broker"** means an organization or entity contracted with the department of social and health services (DSHS)/**medical assistance administration (MAA)** to arrange nonemergency transportation services for MAA's clients.~~

~~**"Drop-off point"** means the place authorized by the transportation broker for the client's trip to end.~~

~~**"Escort"** means a person authorized by the broker to be transported with a client to a medical service. An escort may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.~~

~~**"Guardian"** means a person who is legally responsible for a client and who may be required to be present when a client is receiving medical services.~~

~~**"Local provider of type"** means the medical provider within the client's local community who fulfills the requirements of the medical appointment. The provider may vary by medical specialty, the provider's acceptance of MAA's clients, and whether managed care, primary care case management or third party participation is involved.~~

~~**"Noncompliance"** means a client:~~

~~(1) Engages in violent, seriously disruptive, or illegal conduct;~~

~~(2) Poses a direct threat to the health and/or safety of self or others; or~~

~~(3) Fails to be present at the pickup point of the trip.~~

~~**"Pickup point"** means the place authorized by MAA's transportation broker for the client's trip to begin.~~

~~**"Return trip"** means the return of the client to the client's home, or another authorized return point, from the location where a covered medical service has occurred.~~

~~**"Service mode"** means the method of transportation the transportation broker selects to use for an MAA client.~~

~~**"Stretcher trip"** means a transportation service that requires a client to be transported in a prone or supine position. This may be by stretcher, board or gurney (reclined and with feet elevated). Medical or safety requirements must be the basis for transporting a client in the prone or supine position.~~

~~**"Trip"** means transportation one-way from the **pickup point** to the **drop-off point** by an authorized transportation provider.~~

~~**"Urgent care"** means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day~~)) (1) The department covers nonemergency nonambulance transportation to and from covered healthcare services, as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170) subject to the limitations and require-

ments under WAC 388-546-5000 through 388-546-6200. See WAC 388-546-1000 for nonemergency ground ambulance transportation.

(2) The department pays for nonemergency transportation for clients covered under state-funded medical programs subject to funding appropriated by the legislature.

(3) Clients may not select the transportation provider(s) or the mode of transportation.

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

WAC 388-546-5100 Nonemergency transportation ((program scope of coverage)) Definitions. (((1) The department's health and recovery services administration (HRSA) covers transportation that is necessary for its clients to receive **medically necessary** HRSA covered services. See WAC 388-546-0100 through 388-546-1000 for Ambulance transportation that covers emergency ambulance transportation and limited nonemergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with HRSA's transportation brokers, may be reimbursed for nonemergency transportation services under WAC 388-546-5200 as administrative services.

(3) HRSA covers nonemergency transportation under WAC 388-546-5000 through 388-546-5500 as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (**service mode**).

(4) Prior authorization by HRSA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.

(a) HRSA reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC 388-501-0180, 388-501-0182 and 388-501-0184.

(b) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC 388-501-0184.

(5) HRSA requires all nonemergency transportation to and from covered services to meet the following:

(a) The covered service must be medically necessary as defined in WAC 388-500-0005;

(b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and

(c) Be limited to the **local provider of type** as follows:

(i) Clients receiving services provided under HRSA's fee-for-service program may be transported only to the local provider of type. HRSA's transportation **broker** is responsible for considering and authorizing exceptions.

(ii) Clients enrolled in HRSA's managed care (healthy options) program may be transported to any **provider** supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.

(6) HRSA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by HRSA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC 388-546-5400(1).

(7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.

(8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.

(9) HRSA does not cover any nonemergency transportation service that is not addressed in WAC 388-546-1000 or in 388-546-5000 through 388-546-5500. See WAC 388-501-0160 for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).

(10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.

(11) HRSA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where HRSA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5000 through 388-546-5400, tribal members obtain their transportation services as provided by the tribe or tribal agency.

(12) A client who is denied service under this chapter may request a fair hearing per chapter 388-02 WAC)) The following definitions and those found in WAC 388-500-0005 apply to nonemergency medical brokered transportation. Unless otherwise defined in WAC 388-546-5200 through 388-546-6000, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"Ambulance" - See WAC 388-546-0001.

"Broker" - An organization or entity contracted with the department to arrange nonemergency transportation services for department clients.

"Drop off point" - The location authorized by the transportation broker for the client's trip to end.

"Escort" - A person authorized by the transportation broker to accompany and be transported with a client to a healthcare service. An escort's transportation may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility skills, communication skills, or cultural issues.

"Extended stay" - A period of time spanning seven consecutive days or longer for which a client receives healthcare services outside of his or her local community and for

which he or she may request assistance with meals and/or lodging.

"Guardian" - A person who is legally responsible for a client and who may be required to be present when a client is receiving healthcare services.

"Local community" - The client's city or town of residence or nearest location to residence.

"Local provider" - A provider, as defined in WAC 388-500-0005, who delivers covered healthcare service within the client's local community, and the treatment facility where the services are delivered are also within the client's local community.

"Lodging and meals" - Temporary housing and meals in support of a client's out-of-area medical stay.

"Mode" - A method of transportation assistance used by the general public that an individual client can use in a specific situation. Methods that may be considered include:

- Air transport;
- Bus fares;
- Ferries/water taxis;
- Gas vouchers;
- Grouped or shared-ride vehicles;
- Mileage reimbursement;
- Parking;
- Stretcher vans or cars;
- Taxi;
- Tickets;
- Tolls;
- Volunteer drivers;
- Walking or other personal conveyance; and
- Wheelchair vans.

"Noncompliance or noncompliant" - When a client:

- Fails to appear at the pick-up point of the trip at the scheduled pick-up time;
- Misuses or abuses department-paid medical, transportation, or other services;
- Fails to comply with the rules, procedures, and/or policies of the department and/or those of the department's transportation brokers, the brokers' subcontracted transportation providers, and healthcare service providers;
- Poses a direct threat to the health and/or safety of self or others; or
- Engages in violent, seriously disruptive, or illegal conduct.

"Pickup point" - The location authorized by the department's transportation broker for the client's trip to begin.

"Return trip" - The return of the client to the client's residence, or another authorized drop-off point, from the location where a covered healthcare service has occurred.

"Short stay" - A period of time spanning one to six days for which a client receives healthcare services outside of his or her local community and for which he or she may request assistance with meals and/or lodging.

"Stretcher car or van" - A vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route.

"Stretcher trip" - A transportation service that requires a client to be transported in a prone or supine position without medical attention during the trip. This may be by stretcher, board, gurney, or other appropriate device. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

"Trip" - Transportation one-way from the pickup point to the drop off point by an authorized transportation provider.

"Transportation provider" - An individual or company under contract with a broker, for the provision of trips.

"Urgent care" - An unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day or the following day.

AMENDATORY SECTION (Amending WSR 01-06-029, filed 3/2/01, effective 4/2/01)

WAC 388-546-5200 Nonemergency transportation ((~~program~~)) broker and provider requirements. (1) ((~~MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC 388-546-5100(2).~~

~~(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.~~

~~(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized **trip**.~~

~~(4) MAA's transportation brokers must comply with the terms specified in their contracts.~~

~~(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC 388-546-5300(2)) with the exception of hospital requests or **urgent care** trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.~~

~~(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:~~

~~(a) Provide the transportation in accordance with the broker's instructions and request an after the fact authorization from the transportation broker within seventy-two hours of the transport; or~~

~~(b) Deny the transportation, if the requirements of this section cannot be met.~~

~~(7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:~~

~~(a) Documented as to the reasons retroactive authorization is needed; and~~

~~(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.~~

~~(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:~~

~~(a) Clients are not eligible for transportation services when medical services are within reasonable walking dis-~~

~~tance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));~~

~~(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));~~

~~(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);~~

~~(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100 (1) and (5)(a));~~

~~(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or~~

~~(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.~~

~~(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial~~)) (1) The department requires:

(a) Brokers and subcontracted transportation providers to be licensed, equipped, and operated in accordance with applicable federal, state, local laws, and the terms specified in their contracts;

(b) Brokers to:

(i) Screen their employees and subcontracted transportation providers and employees prior to hiring or contracting, and on an ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 USC 1320a-7 and 42 USC 1320c-5; and

(ii) Report immediately to the department any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 USC 1320a-7 and 42 USC 1320c-5.

(c) Drivers and passengers to comply with all applicable federal, state, and local laws and regulations during transport.

(2) Brokers:

(a) Must determine the level of assistance needed by the client (e.g., curb-to-curb, door-to-door, door-through-door, hand-to-hand) and the mode of transportation to be used for each authorized trip;

(b) Must select the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;

(c) Must have subcontracts with transportation providers in order for the providers to be paid by the broker;

(d) Must provide transportation services comparable to those available to the general public in the local community;

(e) May subcontract with licensed ambulance providers for nonemergency trips in licensed ground ambulance vehicles; and

(f) May contract with a federally recognized tribe within the broker's service region to provide transportation services when requested by that tribe. When the department approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5100 through 388-546-6200, tribal members may obtain their transportation services from the tribe or tribal agency with coordination from and payment through the transportation broker.

(3) If the broker is not open for business and is unavailable to give advance approval for transportation to an urgent care appointment or after a hospital discharge, the subcontracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's instructions and request a retroactive authorization from the broker within two business days of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(4) If the subcontracted transportation provider provides transportation as described in subsection (3)(a) of this section, the broker may agree to grant retroactive authorization and must document the reason in the client's trip record.

AMENDATORY SECTION (Amending WSR 01-06-029, filed 3/2/01, effective 4/2/01)

WAC 388-546-5300 Nonemergency transportation ((~~program~~)) Client ((~~requirements~~)) eligibility. (1) ((~~Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in **noncompliance** may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.~~

~~(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200 (5) and (6).~~

~~(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.~~

~~(4) MAA will cover a clients transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:~~

~~(a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;~~

~~(b) The client's service is covered by a **third party** payer and the payer requires or refers the client to a specific provider;~~

~~(c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;~~

~~(d) The medical service required by the client is not available within the local healthcare service area;~~

~~(e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or~~

~~(f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:~~

~~(i) Documented by the client's primary care provider; and~~

~~(ii) Agreed to by MAA's contracted transportation broker.~~

~~(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.~~

~~(6) If local medical services are not available to a client because of **noncompliance** with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services~~)) The department pays for nonemergency transportation for medical assistance clients, including clients enrolled in a department-contracted managed care organization (MCO), to and from healthcare services when the healthcare service(s) meets the requirements in WAC 388-546-5500.

(2) Clients assigned to the patient review and coordination (PRC) program according to WAC 388-501-0135 may be restricted to certain providers.

(a) Brokers may authorize transportation of a PRC client to only those providers to whom the client is assigned or referred by their primary care provider (PCP), or for covered services which do not require referrals.

(b) If a client assigned to PRC chooses to receive service from a provider, pharmacy, and/or hospital that is not in the client's local community, the client's transportation is limited per WAC 388-546-5700.

AMENDATORY SECTION (Amending WSR 01-06-029, filed 3/2/01, effective 4/2/01)

WAC 388-546-5400 Nonemergency transportation ((~~program general reimbursement limitations~~))—Client responsibility. (1) ((~~To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC 388-546-5100(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:~~

~~(a) When there is medical justification for a shorter trip;~~

~~(b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or~~

~~(c) When the trip involves an area that the broker determines is not physically accessible to the client.~~

~~(2) MAA reimburses for **return trips** from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.~~

~~(3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.~~

~~(4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:~~

~~(a) Transportation to and from an immediate subsequent medical referral; or~~

~~(b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.~~

~~(5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).~~

~~(6) MAA may pay transportation costs, including meals and lodging, for authorized **escorts.** MAA's transportation brokers make the determination that the costs of escorts are necessary based on client need and reasonableness of costs (as measured against state per diem rates).~~

~~(7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.~~

~~(8) MAA may reimburse for the transportation of a **guardian** with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care~~)) Clients must comply with applicable state, local, and federal laws during transport.

(2) Clients must comply with the rules, procedures and/or policies of the department, brokers, the brokers' subcontracted transportation providers and healthcare service providers.

(3) A client who is noncompliant may have limited transportation mode options available.

(4) Clients must request, arrange, and obtain authorization for transportation at least two business days before a healthcare appointment, except when the request is for an urgent care appointment or a hospital discharge.

AMENDATORY SECTION (Amending WSR 10-05-079, filed 2/15/10, effective 3/18/10)

WAC 388-546-5500 ((~~Modifications of privately owned vehicles—Noncovered~~)) Nonemergency transportation—Covered trips. (1) The department ((~~does not cover the purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles under the nonemergency transportation program.~~

~~(2) The purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles is not a healthcare service. Exception to rule (ETR) as described in WAC 388-501-0160 is not available for this nonhealthcare service~~)) covers nonemergency transportation

for medical assistance clients to and from healthcare services when all of the following apply:

(a) The healthcare services are:

(i) Within the scope of coverage of the eligible client's benefit services package; and

(ii) Covered as defined in WAC 388-501-0050 through 388-501-0065 and the specific program rules.

(b) The healthcare service is medically necessary as defined in WAC 388-500-0005;

(c) The healthcare service is being provided as follows (see subsection (3) of this section for exceptions):

(i) Under fee-for-service, by a department-contracted provider;

(ii) Through a department-contract managed care organization (MCO), by an MCO provider; or

(iii) Through a regional support network (RSN), by an RSN contractor.

(d) The trip is to a local provider as defined in WAC 388-546-5100 (see WAC 388-546-5700(3) for local provider exceptions);

(e) The transportation is the lowest cost available mode or alternative that is both accessible to the client and appropriate to the client's medical condition and personal capabilities;

(f) The trip is authorized by the broker in advance of a client's travel; and

(g) The trip is a minimum of three-quarters of a mile from pick-up point to the drop-off point (see WAC 388-546-6200(7) for exceptions to the minimum distance requirement).

(2) Coverage for nonemergency medical transportation is limited to one roundtrip per day, with the exception of multiple medical appointments.

(3) Subsection (1)(c) of this section does not apply if the covered healthcare services is paid for or provided by medicare, a third party insurance, Veteran's Administration, charitable or other voluntary program (Shriners, etc.).

NEW SECTION

WAC 388-546-5550 Nonemergency transportation—Exclusions and limitations. (1) The following service categories cited in WAC 388-501-0060 are subject to the following exclusions and limitations:

(a) Adult day health (ADH) - Nonemergency transportation for ADH services is not provided through the brokers. ADH providers are responsible for arranging or providing transportation to ADH services.

(b) Ambulance - Nonemergency ambulance transportation is not provided through the brokers except as specified in WAC 388-546-5200 (1)(d).

(c) Family planning services - Nonemergency transportation is not provided through the brokers for clients that are enrolled only in TAKE CHARGE or Family Planning Only Services.

(d) Hospice services - Nonemergency transportation is not provided through the brokers when the healthcare service is related to a client's hospice diagnosis. See WAC 388-551-1210.

(e) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, with the exception of DME equipment that needs to be fitted to the client.

(f) Medical nutrition services - Nonemergency transportation is not provided through the brokers to pick up medical nutrition products.

(g) Medical supplies/equipment, nondurable (MSE) - Nonemergency transportation is not provided through the brokers for MSE services.

(h) Mental health services:

(i) Nonemergency transportation brokers generally provide one round trip per day to or from a mental health service. Additional trips for off-site activities, such as a visit to a recreational park, are the responsibility of the provider/facility.

(ii) Nonemergency transportation of involuntarily detained persons under the involuntary treatment act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider. See WAC 388-546-4000.

(i) Substance abuse services - Nonemergency transportation is not provided through the brokers for substance abuse services for clients under the state-funded medical programs (medical care services program (MCS)). See WAC 388-546-5200(2).

(j) Chemical dependency services - Nonemergency transportation is not provided through the brokers to or from the following:

(i) Residential treatment;

(ii) Intensive inpatient;

(iii) Recovery house;

(iv) Long-term treatment;

(v) Information and assistance services, which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(2) The following medical assistance programs have limitations on trips:

(a) State-funded medical care services (MCS) program for clients covered by the disability lifeline program and the alcohol and drug addiction treatment and support act (ADATSA) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to and from medical services as specified in WAC 388-501-0060, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

(b) Transitional bridge waiver for clients covered by the disability lifeline program and the alcohol and drug addiction treatment and support act (ADATSA) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to and from medical services as covered in the transitional bridge waiver approved by the Centers for Medicare and Medicaid Services, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

NEW SECTION

WAC 388-546-5600 Nonemergency transportation—Intermediate stops or delays. (1) The department does not pay for any costs related to intermediate stops or delays that are not directly related to the original approved trip, including trips that would, or did, result in additional transportation costs due to client convenience.

(2) Brokers may authorize intermediate stops or delays for clients if the broker determines that the intermediate stop is:

(a) Directly related to the original approved trip; or

(b) Likely to limit or eliminate the need for supplemental covered trips.

(3) The department considers the following reasons to be related to the original trip:

(a) Transportation of the client to and from an immediate subsequent medical referral/appointment; or

(b) Transportation of the client to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the usual route to the medical appointment.

NEW SECTION

WAC 388-546-5700 Nonemergency transportation—Local provider and trips outside client's local community. (1) Clients receiving services provided under fee-for-service and/or through a department contracted managed care organization are transported to a local provider only.

(a) A local provider's medical specialty may vary as long as the provider is capable of providing medically necessary care that is the subject of the appointment or treatment;

(b) A provider's acceptance of the departments' clients may determine if the provider may be considered as an available local provider, along with whether managed care, primary care case management, or third party participation is involved.

(2) Brokers are responsible for considering and authorizing exceptions. See subsection (3) of this section for exceptions.

(3) A broker may transport a client to a provider outside the client's local community for covered healthcare services when any the following apply:

(a) The healthcare service is not available within the client's local community.

(i) If requested by the broker, the client must provide documentation from the client's primary care provider (PCP), specialist or other appropriate provider verifying the medical necessity for the client to be served by a healthcare provider outside of the client's local community.

(ii) If the service is not available in the client's local community, transportation may be authorized to the nearest provider where the service may be obtained.

(b) The transportation to a provider outside the client's local community is required for continuity of care.

(i) If requested by the broker, the client or their provider must submit documentation from the client's PCP, specialist or other appropriate provider verifying the existence of ongoing treatment for medically necessary care by the provider and the medical necessity for the client to continue to be served by the healthcare provider.

(ii) If the broker authorizes transportation to a provider outside the client's local community based on continuity of care, this authorization is for a limited period of time for completion of ongoing care for a specific medical condition. Each transport must be related to the ongoing treatment of the specific condition that requires continuity of care.

(iii) Ongoing treatment of medical conditions that may qualify for transportation based on continuity of care, include but are not limited to:

(A) Active cancer treatment;

(B) Recent transplant (within the last twelve months);

(C) Scheduled surgery (within the next sixty days);

(D) Major surgery (within the previous sixty days); or

(E) Third trimester of pregnancy.

(c) The healthcare service is paid by a third payer who requires or refers the client to a specific provider within their network;

(d) The total cost to the department, including transportation costs, is lower when the healthcare service is obtained outside of the client's local community; and

(e) A provider outside the client's local community has been issued a global payment by the department for services the client will receive and the broker determines it to be cost effective to provide transportation for the client to complete treatment with this provider.

(4) Brokers determine whether an exception should be granted based on documentation from the client's healthcare providers and program rules. Brokers may refer requests to transport a client to a provider outside the client's local community for healthcare services to the department's medical director or the medical director's designee for review and/or authorization.

(5) When a client or a provider moves to a new community, the existence of a provider-client relationship, independent of other factors, does not constitute a medical need for the broker to authorize and pay for transportation to the previous provider.

(6) The healthcare service must be provided in the state of Washington or a designated border city, unless the department specifically authorizes transportation to an out of state provider in accordance with WAC 388-546-5800.

(7) The department does not authorize and pay for nonemergency transportation to providers outside the client's local community if the client's noncompliance is the reason a local healthcare provider or service is not available.

NEW SECTION

WAC 388-546-5800 Nonemergency transportation—Trips out-of-state/out-of-country. (1) The department reviews requests for out-of-state nonemergency transportation in accordance with regulations for covered healthcare services, including WAC 388-501-0180, 388-501-0182 and 388-501-0184.

(2) Nonemergency transportation is not provided to or from locations outside of the United States and U.S. territories, except for the limitations for British Columbia, Canada, identified in WAC 388-501-0184.

NEW SECTION

WAC 388-546-5900 Nonemergency transportation—Meals, lodging, escort/guardian. (1) The department may pay for meals and lodging for clients who must be transported to healthcare services outside of the client's local community. The department's transportation brokers determine when meals and lodging are necessary based on a client's individual need.

(2) Brokers may authorize payment for meals and lodging for up to one calendar month. Extensions beyond the initial calendar month must be prior authorized by the broker on a month-to-month, week-to-week, or as-needed basis.

(3) Brokers follow the department's guidelines in determining the reasonable costs of meals and lodging. The department's guidelines are:

(a) The reasonable cost of lodging for short and extended stays is measured against state per diem rates.

(b) For short stays, the cost of meals is measured against the state per diem rate.

(c) For extended stays, the reasonable cost of meals is measured against the state's basic food program. The maximum monthly allowable meal cost for extended stays is not to exceed the client's calculated monthly food benefit or state per diem rates.

(4) The department pays for the transportation of an authorized escort, including meals and lodging, when all of the following apply:

(a) The client is present, with the exception of subsection (5) of this section; and

(b) The broker determines the transportation costs of escorts are necessary based upon the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.

(5) The department may authorize and pay for the transportation of an authorized escort or guardian, with or without the presence of the client, if the broker determines and documents the presence of the authorized escort or guardian is necessary to ensure that the client has access to medically necessary care.

(6) Lodging and meals for all out-of-state nonemergency transportation must be prior authorized by the department. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.

NEW SECTION

WAC 388-546-6000 Nonemergency transportation—Authorization. (1) The department contracts with brokers to authorize or deny requests for transportation services.

(2) Brokers may refer requests to transport a client to a provider to the department's medical director or designee for a review and/or authorization.

(3) Nonemergency medical transportation, other than ambulance, must be prior authorized by the broker. See WAC 388-546-5200 (3) and (4) and WAC 388-546-6200(4) for granting retroactive authorization.

(4) The broker mails a written notice of denial to each client who is denied authorization of transportation.

(5) A client who is denied nonemergency transportation under this chapter may request an administrative hearing, if one is available under state and federal law.

(6) If the department approves a medical service under exception to rule (ETR), the authorization requirements of this section apply to transportation services related to the ETR service.

NEW SECTION

WAC 388-546-6100 Nonemergency transportation—Noncovered. (1) The department does not cover any nonemergency transportation that is not specifically addressed in WAC 388-546-5000 through 388-546-6200.

(2) Brokers do not provide nonemergency transportation for admissions under the involuntary treatment act (ITA), as defined in WAC 388-546-4000.

(3) The department does not provide escorts or cover the cost of wages of escorts.

(4) The department does not cover the purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles under the nonemergency transportation program. The purchase or repair of equipment for a privately owned vehicle or modification of a privately owned vehicle is not a healthcare service. Exception to rule (ETR) as described in WAC 388-501-0160 is not available for this nonhealthcare service.

NEW SECTION

WAC 388-546-6200 Nonemergency transportation—Reimbursement. (1) To be reimbursed for trips, meals, and lodging, the requestor must receive prior authorization from the broker at least forty-eight hours in advance of the client's travel.

(2) A client must request reimbursement of preauthorized expenditures for trips, meals, and lodging within thirty days after his or her medical appointment(s). The broker may consider reimbursement requests beyond thirty days if a client shows good cause as defined in WAC 388-02-0020 for having not requested reimbursement within thirty days.

(3) To be reimbursed for mileage, fuel/gas, parking, bridge tolls, and ferry fees, the requestor must provide the broker with legible copies of:

(a) Receipt(s);

(b) The operator's driver license;

(c) Current vehicle registration; and

(d) Proof of insurance for the vehicle/operator at the time of the trip.

(4) The department or the broker may retroactively authorize and reimburse for transportation costs, including meals and lodging when:

(a) A client is approved for a retroactive eligibility period, or is approved for a delayed certification period as defined in WAC 388-500-0005;

(b) The transportation costs were not used to meet a client spenddown liability in accordance with WAC 388-519-0110;

(c) The transportation costs for which retroactive reimbursement is requested falls within the period of retroactive eligibility or delayed certification;

(d) The client received medically necessary services that were covered by their medical program for the date(s) of service for which retroactive reimbursement is requested; and

(e) The request for retroactive reimbursement is made within sixty days from the date of eligibility notification (award letter), not to exceed eight months from the date(s) of service for which reimbursement is requested.

(5) When transportation cost(s) are retroactively authorized, the reimbursement amount must not exceed the reimbursement amount that would have been authorized prior to the date(s) of service.

(6) To be paid by the broker for nonemergency transportation services:

(a) Ambulance providers must be subcontracted with the broker in accordance with WAC 388-546-5200 (1)(d).

(b) Nonambulance providers must be subcontracted with the broker in accordance with WAC 388-546-5200 (1)(c).

(7) The department, through its contracted brokers, does not pay for nonemergency transportation when:

(a) The healthcare service the client is requesting transportation to or from is not a service covered by the client's medical program.

(b) The covered healthcare service is within three-quarters of a mile from the pick-up point, except when:

(i) The client's documented and verifiable medical condition and personal capabilities demonstrates that the client is not able to walk three-quarters mile distance;

(ii) The trip involves an area that the broker determines is not physically accessible to the client; or

(iii) The trip involves an area that the department's broker considers to be unsafe for the client, other riders, or the driver.

(c) The client has personal or informal transportation resources that are available and appropriate to the clients' needs;

(d) Fixed-route public transportation service is available to the client within three-quarters of a mile walking distance. Exceptions to this rule may be granted by the transportation broker when the need for more specialized transportation is documented. Examples of such a need may be the client's use of a portable ventilator, a walker, or a quad cane; or

(e) The mode of transport that the client requests is not necessary, suitable, or appropriate to the client's medical condition.

WSR 11-16-008
PERMANENT RULES
DEPARTMENT OF ECOLOGY

[Order 09-04—Filed July 21, 2011, 3:41 p.m., effective August 21, 2011]

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

Purpose: Ecology is adopting chapter 173-334 WAC, the Children's Safe Product Act reporting rule. As signed into law, the Children's Safe Product Act (chapter 70.240 RCW) requires manufacturers of children's products to report the presence of chemicals of high concern to children (CHCCs) to the department. The purpose of the rule is to clarify the following: The process to be used to update the reporting list for CHCCs, definitions of several key terms, and the reporting process.

Statutory Authority for Adoption: Children's Safe Product Act (CSPA), RCW 70.240.040.

Adopted under notice filed as WSR 11-10-088 on May 4, 2011.

A final cost-benefit analysis is available by contacting John R. Williams Jr., P.O. Box 47600, Olympia, WA 98504-7600, phone (360) 407-6940, fax (360) 407-6102, e-mail john.williams@ecy.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 13, 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 13, 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 13, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: July 21, 2011.

Ted Sturdevant
Director

Chapter 173-334 WAC

CHILDREN'S SAFE PRODUCTS - REPORTING RULE

NEW SECTION

WAC 173-334-010 Introduction. Under the Children's Safe Product Act (CSPA), chapter 70.240 RCW, manufacturers of children's products are required to notify the department of ecology when a chemical of high concern to children (CHCC) is present in their products or, if the product contains more than one component, each product component.

The presence of a CHCC in a children's product does not necessarily mean that the product is harmful to human health or that there is any violation of existing safety standards or laws. The reported information will help fill a data gap that exists for both consumers and agencies.

The CSPA requires the department of ecology in consultation with the department of health to identify a list of chemicals for which manufacturers of children's products are required to provide notice. The CSPA specifies both the characteristics of these chemicals and the notice requirements.

NEW SECTION

WAC 173-334-020 What is the purpose of this chapter? The purpose of this chapter is to:

(1) Establish the list of chemicals for which manufacturer notice is required;

(2) Establish what manufacturers of children's products must do to comply with the notice requirements created by the CSPA; and

(3) Clarify the enforcement processes the department of ecology will use if manufacturers fail to provide notice as required.

NEW SECTION

WAC 173-334-030 To whom does this chapter apply? This chapter applies to manufacturers of children's products.

NEW SECTION

WAC 173-334-040 What definitions apply to terms used in this chapter? "Chemical Abstracts Service number" means the number assigned for identification of a particular chemical by the Chemical Abstracts Service, a service of the American Chemical Society that indexes and compiles abstracts of worldwide chemical literature called *Chemical Abstracts*.

"CHCC list" means the reporting list of chemicals that the department has identified as high priority chemicals of high concern for children.

"Child" means an individual under twelve.

"Children's product" has the same meaning as defined in RCW 70.240.010.

(a) For the purposes of this rule, children's products only include products that are sold, or are to be offered for sale, to consumers in the state of Washington.

(b) In addition to the exemptions specified in RCW 70.240.010, for the purposes of this rule, "children's product" does not include over the counter drugs, prescription drugs, food, dietary supplements, packaging, medical devices, or products that are both a cosmetic and a drug regulated by the Food and Drug Administration.

(c) A product label that includes usage instructions for use of a product that apply to children does not in and of itself establish that the product is a children's product.

"Contaminant" means trace amounts of chemicals that are incidental to manufacturing. They serve no intended function in the product component. They can include, but are not limited to, unintended by-products of chemical reactions during the manufacture of the product component, trace impurities in feed-stock, incompletely reacted chemical mixtures, and degradation products.

"Department of health" means the Washington state department of health.

"Intentionally added chemical" means a chemical in a product that serves an intended function in the product component.

"Manufacturer" means the producer, importer, or wholesale domestic distributor of a children's product and is more specifically defined in RCW 70.240.010. For the purposes of this rule, a retailer of a children's product is not a manufacturer unless it is also the producer, manufacturer, importer, or domestic distributor of the product.

"Mouthable" means able to be brought to the mouth and kept in the mouth by a child so that it can be sucked and chewed. If the product can only be licked, it is not able to be placed in the mouth. If a product or part of a product in one dimension is smaller than five centimeters, it can be placed in the mouth.

"Practical quantification limit (PQL)" means the lowest concentration that can be reliably measured within specified limits of precision, accuracy, representativeness, completeness, and comparability during routine laboratory operating conditions. This value is based on scientifically defensible, standard analytical methods. The value for a given chemical could be different depending on the matrix and the analytical method used.

"Product category" means the "brick" level of the GS1 Global Product Classification (GPC) standard, which identifies products that serve a common purpose, are of a similar form and material, and share the same set of category attributes.

"Product component" means a uniquely identifiable material or coating (including ink or dye) that is intended to be included as a part of a finished children's product.

NEW SECTION

WAC 173-334-050 What is the purpose of the CHCC list? The CHCC list identifies the chemicals to which the notice requirements apply. A manufacturer must notify the department in accordance with WAC 173-334-080 if a chemical on the CHCC list is present in a children's product component. The current CHCC list is set forth in WAC 173-334-130.

NEW SECTION

WAC 173-334-060 How can the department revise the CHCC list? The department can only add chemicals to, or remove chemicals from, the CHCC list by amending this rule in accordance with the requirements of the Administrative Procedure Act, chapter 34.05 RCW.

NEW SECTION

WAC 173-334-070 How will the department identify chemicals for inclusion in the CHCC list? (1) The department will consult with the department of health during the modification of the CHCC list.

(2) A chemical that the department determines to meet all of the following criteria may be included on the CHCC list:

(a) The toxicity, persistence, or bioaccumulativity criteria specified in RCW 70.240.010(6); and

(b) The exposure criteria specified in RCW 70.240.030 (1).

(3) The department will consider both the parent chemical and its degradation products when deciding whether a chemical meets the criteria of this section. If a parent chemical does not meet the criteria in this section but degrades into chemicals that do, the parent chemical may be included on the CHCC list.

(4) A person may submit a petition for consideration by the department to add a chemical to or remove a chemical from the CHCC list. The petition must provide the following information:

(a) Chemical Abstracts Service registry number;

(b) Chemical prime name; and

(c) Credible peer-reviewed scientific information documenting why the chemical meets or fails to meet the criteria required for inclusion on the list.

(5) The department shall review petitions in accordance with RCW 34.05.330, the Administrative Procedure Act.

NEW SECTION

WAC 173-334-080 What must the manufacturer include in its notice to the department? (1) The notice required by RCW 70.240.040 must be filed annually with the department in accordance with the following:

(a) Each chemical on the CHCC list that is an intentionally added chemical present in a product component must be reported at any concentration above the PQL.

(b) Each chemical on the CHCC list that is a contaminant present in a product component must be reported at any concentration above 100 ppm. A manufacturer need not file a notice with respect to any CHCC that occurs in a product component only as a contaminant if the manufacturer had in place a manufacturing control program and exercised due diligence to minimize the presence of the contaminant in the component.

(2) The notice must include all of the following information:

(a) The name of the CHCC and its Chemical Abstracts Service registry number.

(b) The product category or categories in which it occurs.

(c) The product component or components within each product category in which it occurs.

(d) A brief description of the function, if any, of the CHCC in each product component within each product category.

(e) The total amount of the CHCC by weight contained in each product component within each product category. The amount may be reported in ranges, rather than the exact amount. If there are multiple CHCC values for a given component in a particular product category, the manufacturer must use the largest value for reporting.

For the purpose of this rule, the reporting ranges are as follows:

(i) Equal to or more than the PQL but less than 100 ppm (0.01%);

(ii) Equal to or more than 100 ppm (0.01%) but less than 500 ppm (0.05%);

(iii) Equal to or more than 500 ppm (0.05%) but less than 1,000 ppm (0.10%);

(iv) Equal to or more than 1,000 ppm (0.10%) but less than 5,000 ppm (0.5%); or

(v) Equal to or more than 5,000 ppm (0.5%) but less than 10,000 ppm (1.0%); or

(vi) Equal to or more than 10,000 ppm (1.0%).

(f) The name and address of the reporting manufacturer or trade organization and the name, address and phone number of the contact person for the reporting manufacturer or trade organization. When a trade organization is the reporting party, the report must include a list of the manufacturers on whose behalf the trade organization is reporting, and all of the information that would otherwise be required of the individual manufacturers.

(g) Any other information the manufacturer deems relevant to the appropriate use of the product.

(3) Reporting parties are not required to include either:

(a) Any specific formula information; or

(b) The specific name and address of the facility which is responsible for the introduction of a CHCC into a children's product or product component.

(4) If a reporting party believes the information being provided is confidential business information (CBI), in whole or in part, it may request that the department treat the information as confidential business information as provided in RCW 43.21A.160. The department will use its established procedures to determine how it will handle the information.

(5) The department will make available the current version of the web form to be used for reporting on CHCCs. This same form may be used by the reporting party to flag the submitted information it thinks should be treated as CBI. The web form must be used when providing notification.

(6) Any information that is not determined to be confidential business information will be available to the public. As resources allow, the department will post this information on the department's web site.

NEW SECTION

WAC 173-334-090 Who is required to provide notice to the department? (1) The manufacturer of a children's product, or a trade organization on behalf of its member manufacturers, must provide notice to the department that the manufacturer's children's product component contains a chemical on the CHCC list.

(2) The definition of manufacturer in RCW 70.240.010 includes any person or entity that produces a children's product, any importer that assumes ownership of a children's product, and any domestic distributor of a children's product. However, it is only necessary for one person or entity to provide notice with respect to a particular children's product.

The following hierarchy will determine which person or entity the department will hold primarily responsible for ensuring that the department receives a complete, accurate, and timely notice for the children's product:

(a) The person or entity that had the children's product manufactured, unless it has no presence in the United States.

(b) The person or entity that marketed the children's product under its name or trademark, unless it has no presence in the United States.

(c) The first person or entity, whether an importer or a distributor, that owned the children's product in the United States.

NEW SECTION

WAC 173-334-100 What time period is covered by the notice? Manufacturers must provide notice as required by WAC 173-334-110 on an annual basis for children's prod-

ucts that have been manufactured for sale in Washington during the twelve-month period that precedes the applicable due date for first notices set out in WAC 173-334-110(2). If the reporting party determines that there has been no change in the information required to be reported since the prior annual notice, the party may submit a written statement indicating that the previous reported data is still valid, in lieu of a new duplicate complete notice.

If a CHCC is subsequently removed from the children's product component for which notice was given, the manufacturer may provide notice to the department. Such updated notices will be documented in the department's records.

NEW SECTION

WAC 173-334-110 When must manufacturers begin to provide notice? (1) This section establishes when manufacturers must first provide notice to the department if a children's product contains a chemical on the CHCC list. The notice requirement will be phased in as provided in the schedule set out in subsection (2) of this section based on the manufacturer categories and children's product tiers established in subsections (3) and (4) of this section. After the first notice date, notice must be provided annually on the anniversary of the first notice.

(2) The following table specifies when the first annual notice must be provided to the department in compliance with RCW 70.240.040. The due date will be determined by counting the number of months specified in the table, beginning with the first calendar month following the calendar month in which this rule is adopted. The notice will be considered delinquent if not received by the department by the last day of the month indicated.

Notice due dates from adoption date of rule, values are in months.

Manufacturer categories	Product Tier 1	Product Tier 2	Product Tier 3	Product Tier 4
Largest	12	18	24	case-by-case
Larger	18	24	36	case-by-case
Medium	24	36	48	case-by-case
Small	36	48	60	case-by-case
Smaller	48	60	72	case-by-case
Tiny	60	72	84	case-by-case

(3) For the purpose of this rule the department recognizes six categories of manufacturers. The categories of manufacturers are as follows:

(a) "Largest manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of more than one billion dollars, based on the manufacturer's most recent tax year filing.

(b) "Larger manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of more than two hundred fifty million but less than or equal to one billion dollars, based on the manufacturer's most recent tax year filing.

(c) "Medium size manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of more than one hundred million but less than or equal to two hundred fifty million dollars, based on the manufacturer's most recent tax year filing.

(d) "Small manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of more than five million but less than or equal to one hundred million dollars, based on the manufacturer's most recent tax year filing.

(e) "Smaller manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of more than one hundred thousand but less than or equal to five million dollars, based on the manufacturer's most recent tax year filing.

(f) "Tiny manufacturer" means any manufacturer of children's products with annual aggregate gross sales, both within and outside of Washington, of less than one hundred thousand dollars, based on the manufacturer's most recent tax year filing.

(4) For the purpose of this rule the department recognizes four tiers of products. The tiers or products are as follows:

(a) Tier 1 - Children's products intended to be put into a child's mouth (e.g., children's products used for feeding, sucking, some toys) or applied to the child's body (e.g., children's products used as lotions, shampoos, creams), or any mouthable children's product intended for children who are age three or under.

(b) Tier 2 - Children's products intended to be in prolonged (more than one hour) direct contact with a child's skin (e.g., clothes, jewelry, bedding).

(c) Tier 3 - Children's products intended for short (less than one hour) periods of direct contact with child's skin (e.g., many toys).

(d) Tier 4 - Children's product components that during reasonably foreseeable use and abuse of the product would not come into direct contact with the child's skin or mouth (e.g., inaccessible internal components for all children's products). Reporting for Tier 4 components will not be required, except by amendment of this rule, based on a case-by-case evaluation by the department.

NEW SECTION

WAC 173-334-120 How will this chapter be enforced? (1) The department may collect children's products subject to possible reporting, and analyze their components for the presence of CHCCs. If the department finds that a children's product component contains a chemical on the CHCC list that the manufacturer either has not reported, or has reported at a lesser amount, the department will notify the manufacturer in writing. The department will then afford the manufacturer forty-five days from receipt of the department's notification to respond to the findings before the department takes further enforcement action.

In determining whether a violation of the CSPA or these rules has occurred, the department will consider the manufacturer's timely explanation as to why it did not report the presence or accurate amount of the CHCC in the product component. If the manufacturer asserts that the CHCC is present in the component only as a contaminant, and that the manufac-

turer did not report the CHCC's presence based on WAC 173-334-080 (1)(b), then the manufacturer must present evidence that it conducted a reasonable manufacturing control program for the CHCC contaminant and exercised due diligence as described in subsections (2) and (3) of this section.

If the manufacturer contests the department's findings regarding the presence or amount of the CHCC in the product component, the manufacturer may further analyze the component in question for presence of CHCC and provide the department with a copy of its own laboratory findings for the component.

(2) Manufacturing control program. A reasonable manufacturing control program must include industry best manufacturing practices for the minimization of the CHCC in the children's product. Those practices may include, but are not limited to, methods and procedures for meeting relevant federal regulations, International Standards Organization (ISO) requirements, American Society for Testing and Materials (ASTM) standards, and other widely established certification or standards programs.

(3) Due diligence. Actions demonstrating due diligence in ensuring the effectiveness of a manufacturing control program may include the use and enforcement of contract specifications, procedures to ensure the quality/purity of feedstock (whether raw or recycled), the use and enforcement of contract specifications for manufacturing process parameters (e.g., drying and curing times when relevant to the presence of high priority chemicals in the finished children's product components), periodic testing for the presence and amount of CHCCs, auditing of contractor or supplier manufacturing processes, and other practices reasonably designed to ensure the manufacturer's knowledge of the presence, use, and amount of CHCCs in its children's product components.

(4) If the department determines based on the process described in subsection (1) of this section, or on other grounds, that a manufacturer has violated a requirement of the CSPA or these rules, it may require the manufacturer to pay a civil penalty. A manufacturer of children's products in violation of this chapter is subject to a civil penalty not to exceed five thousand dollars for each violation in the case of a first offense. Manufacturers who are repeat violators are subject to a civil penalty not to exceed ten thousand dollars for each repeat offense. Penalties collected under this section must be deposited in the state toxics control account created in RCW 70.105D.070.

(5) A single violation consists of a manufacturer failing to provide the required notice for the presence and accurate amount of each CHCC, in each applicable product category, in each applicable product component.

NEW SECTION

WAC 173-334-130 The reporting list of chemicals of high concern to children (CHCC list).

CAS	Chemical
50-00-0	Formaldehyde
62-53-3	Aniline
62-75-9	N-Nitrosodimethylamine
71-36-3	n-Butanol
71-43-2	Benzene
75-01-4	Vinyl chloride
75-07-0	Acetaldehyde
75-09-2	Methylene chloride
75-15-0	Carbon disulfide
78-93-3	Methyl ethyl ketone
79-34-5	1,1,2,2-Tetrachloroethane
79-94-7	Tetrabromobisphenol A
80-05-7	Bisphenol A
84-66-2	Diethyl phthalate
84-74-2	Dibutyl phthalate
84-75-3	Di-n-Hexyl phthalate
85-44-9	Phthalic anhydride
85-68-7	Butyl benzyl phthalate (BBP)
86-30-6	N-Nitrosodiphenylamine
87-68-3	Hexachlorobutadiene
94-13-3	Propyl paraben
94-26-8	Butyl paraben
95-53-4	2-Aminotoluene
95-80-7	2,4-Diaminotoluene
99-76-3	Methyl paraben
99-96-7	p-Hydroxybenzoic acid
100-41-4	Ethylbenzene
100-42-5	Styrene
104-40-5	4-Nonylphenol; 4-NP and its isomer mixtures including CAS 84852-15-3 and CAS 25154-52-3
106-47-8	para-Chloroaniline
107-13-1	Acrylonitrile
107-21-1	Ethylene glycol
108-88-3	Toluene
108-95-2	Phenol
109-86-4	2-Methoxyethanol
110-80-5	Ethylene glycol monoethyl ester
115-96-8	Tris(2-chloroethyl) phosphate
117-81-7	Di-2-ethylhexyl phthalate
117-84-0	Di-n-octyl phthalate (DnOP)
118-74-1	Hexachlorobenzene
119-93-7	3,3'-Dimethylbenzidine and Dyes Metabolized to 3,3'-Dimethylbenzidine
120-47-8	Ethyl paraben
123-91-1	1,4-Dioxane
127-18-4	Perchloroethylene
131-55-5	Benzophenone-2 (Bp-2); 2,2',4,4'-Tetrahydroxybenzophenone
140-66-9	4-tert-Octylphenol; 1,1,3,3-Tetramethyl-4-butylphenol
140-67-0	Estragole

CAS	Chemical
149-57-5	2-Ethylhexanoic acid
556-67-2	Octamethylcyclotetrasiloxane
608-93-5	Benzene, pentachloro
842-07-9	C.I. solvent yellow 14
872-50-4	N-Methylpyrrolidone
1163-19-5	2,2',3,3',4,4',5,5',6,6'-Decabromodiphenyl ether; BDE-209
1763-23-1	Perfluorooctanyl sulphonic acid and its salts; PFOS
1806-26-4	Phenol, 4-octyl-
5466-77-3	2-Ethyl-hexyl-4-methoxycinnamate
7439-97-6	Mercury & mercury compounds including methyl mercury (22967-92-6)
7439-98-7	Molybdenum & molybdenum compounds
7440-36-0	Antimony & Antimony compounds
7440-38-2	Arsenic & Arsenic compounds including arsenic trioxide (1327-53-3) & dimethyl arsenic (75-60-5)
7440-43-9	Cadmium & cadmium compounds
7440-48-4	Cobalt & cobalt compounds
25013-16-5	Butylated hydroxyanisole; BHA
25637-99-4	Hexabromocyclododecane
26761-40-0	Diisodecyl phthalate (DIDP)
28553-12-0	Diisononyl phthalate (DINP)

WSR 11-16-015
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-167—Filed July 22, 2011, 3:48 p.m., effective August 22, 2011]

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

Purpose: To expand the benefit of the spring seasons in northeastern Washington, the department is increasing permit levels and season length. The anticipated effect is a slight increase in total harvest and reduced bear nuisance activity.

For westside spring bear hunts, the department is recommending increasing the season length in the Kapowsin Tree Farm unit from April 15-May 15 to April 15-June 15, based on discussions with the landowners. There is a slight anticipated increase to the number of hunter days.

Reasons Supporting Proposal: The objectives for spring bear hunting seasons are to reduce timber damage by bears (western Washington), reduce nuisance bear activity (northeastern Washington), and to divert harvest away from adult females and toward adult males (southeastern Washington).

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-286.

Statutory Authority for Adoption: RCW 77.12.047.

Adopted under notice filed as WSR 11-03-089 on January 19, 2011.

Changes Other than Editing from Proposed to Adopted Version:

- In the spring bear hunt table, for Sherman, Kelly Hill, Aladdin, 49 Degrees North, and Huckleberry hunts, the permit level was increased to 25. In the Douglas hunt, the permit level was increased to 20. These changes address nuisance complaints regarding bears in the spring. The increased permit level will likely have no significant effects to the bear population status.
- In the spring bear hunt table, for the Kapowsin hunt, the closing date was changed from May 15 to June 15. The reason for this change was to address bear damage to trees throughout the entire damage season, which continues through mid-June. The increased permit level will likely have no significant effects to the bear population status.

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

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

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

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

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

Date Adopted: April 8, 2011.

Miranda Wecker, Chair
Fish and Wildlife Commission

AMENDATORY SECTION (Amending Orders 10-94 and 10-94A, filed 4/30/10 and 12/30/10, effective 5/31/10 and 1/30/11)

WAC 232-28-286 2010, 2011, and 2012 Spring black bear seasons and regulations. It is unlawful to fail to comply with the provisions below. Violators may be punished under RCW 77.15.410, 77.15.245, and 77.15.280 (1)(c).

Who may apply: Anyone with a valid Washington big game license, which includes black bear as a species option.

Hunt areas, permit levels, and season dates for each license year:

Hunt name	Hunt area	Permits	Season dates[b]
Sherman	GMU 101	((~~19~~)) 25	((~~April 15 - May 31~~)) April 1 - June 15
Kelly Hill	GMU 105	((~~13~~)) 25	((~~April 15 - May 31~~)) April 1 - June 15
Douglas	GMU 108	((~~7~~)) 20	((~~April 15 - May 31~~)) April 1 - June 15
Aladdin	GMU 111	((~~13~~)) 25	((~~April 15 - May 31~~)) April 1 - June 15
49 Degrees North	GMU 117	((~~19~~)) 25	((~~April 15 - May 31~~)) April 1 - June 15
Huckleberry	GMU 121	((~~19~~)) 25	((~~April 15 - May 31~~)) April 1 - June 15
Blue Creek	GMU 154	15	April 15 - May 31
Dayton	GMU 162	15	April 15 - May 31
Tucannon	GMU 166	5	April 15 - May 31
Wenaha	GMU 169	45	April 15 - June 15
Mt. View	GMU 172	15	April 15 - May 31
Lick Creek	GMU 175	15	April 15 – May 31
Couse	GMU 181	4	April 15 - May 31
Grande Ronde	GMU 186	5	April 15 - May 31
North Skagit	That portion of GMU 418 that is designated as the hunt area by DNR, Sierra Pacific, and Grandy Lake Timber company.	20	April 15 - May 31
Monroe	That portion of GMU 448 that is designated as the hunt area by DNR, Green Crow, and Longview Timber Lands.	25	April 15 - May 31
Copalis[a]	That portion of GMU 642 that is designated as the hunt area by Rayonier Timber Company.	100	April 15 - June 15
Kapowsin[a]	That portion of GMUs 653 and/or 654 that is designated as the hunt area by Hancock Forest Management and International Forestry.	150	April 15 - ((~~May~~)) June 15
Lincoln[a]	That portion of GMU 501 that is designated as the hunt area by participating commercial timber landowners.	75	April 15 - June 15
[a]Spring black bear hunting seasons under this area constitute a pilot program to reduce black bear damage to trees.			
[b]Permits are valid for the license year they are issued.			

Bag limit: One black bear per black bear special permit season.

License required: A valid big game hunting license, which includes black bear as a species option, is required to hunt black bear. One black bear transport tag is included with a big game hunting license that has black bear as a species option.

Hunting method: Hunters may use any lawful big game modern firearm, archery, or muzzleloader equipment for hunting black bear. The use of dogs or bait to hunt black bear is prohibited statewide.

Submitting bear teeth: Successful bear hunters must submit the black bear premolar located behind the canine tooth of the upper jaw.

WSR 11-16-016
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-165—Filed July 22, 2011, 4:08 p.m., effective August 22, 2011]

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

Purpose: Amend rules for commercial salmon fishing [in] Puget Sound, including WAC 220-47-307, 220-47-311, 220-47-401, 220-47-411, 220-47-427, and 220-47-428.

Citation of Existing Rules Affected by this Order: Amending WAC 220-47-307, 220-47-311, 220-47-401, 220-47-411, 220-47-427, and 220-47-428.

Statutory Authority for Adoption: RCW 77.04.020, 77.12.045, and 77.12.047.

Adopted under notice filed as WSR 11-12-002 on May 18, 2011, and WSR 11-07-090 on March 22, 2011.

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 6, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 6, 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: July 22, 2011.

Philip Anderson
Director

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-307 Closed areas—Puget Sound salmon. It is unlawful at any time, unless otherwise provided, to take, fish for, or possess salmon taken for commercial purposes with any type of gear from the following portions of Puget Sound Salmon Management and Catch Reporting Areas, except that closures listed in this section do not apply to reef net fishing areas listed in RCW 77.50.050:

Areas 4B, 5, 6, 6B, and 6C - The Strait of Juan de Fuca Preserve as defined in WAC 220-47-266.

Area 6D - That portion within 1/4-mile of each mouth of the Dungeness River.

Area 7 - (1) The San Juan Island Preserve as defined in WAC 220-47-262.

(2) Those waters within 1,500 feet of shore on Orcas Island from Deer Point northeasterly to Lawrence Point, thence west to a point intercepting a line projected from the northernmost point of Jones Island, thence 90° true to Orcas Island.

(3) Those waters within 1,500 feet of the shore of Cypress Island from Cypress Head to the northernmost point of Cypress Island.

(4) Those waters easterly of a line projected from Iceberg Point to Iceberg Island, to the easternmost point of Charles Island, then true north from the northernmost point of Charles Island to the shore of Lopez Island.

(5) Those waters northerly of a line projected from the southernmost point of land at Aleck Bay to the westernmost point of Colville Island, thence from the easternmost point of Colville Island to Point Colville.

(6) Those waters easterly of a line projected from Biz Point on Fidalgo Island to the Williamson Rocks Light, thence to the Dennis Shoal Light, thence to the light on the westernmost point of Burrows Island, thence to the southwestern-most point of Fidalgo Head, and including those waters within 1,500 feet of the western shore of Allan Island, those waters within 1,500 feet of the western shore of Burrows Island, and those waters within 1,500 feet of the shore of Fidalgo Island from the southwestern-most point of Fidalgo Head northerly to Shannon Point.

(7) Additional Fraser sockeye and pink seasonal closure: Those waters within 1,500 feet of the shore of Fidalgo Island from the Initiative 77 marker northerly to Biz Point.

(8) Those waters within 1,500 feet of the eastern shore of Lopez Island from Point Colville northerly to Lopez Pass, and those waters within 1,500 feet of the eastern shore of Decatur Island from the southernmost point of land northerly to Fauntleroy Point, and including those waters within 1,500 feet of the shore of James Island.

Area 7A - The Drayton Harbor Preserve as defined in WAC 220-47-252.

Area 7B - That portion south and east of a line from William Point on Samish Island to Saddlebag Island to the southeastern tip of Guemes Island, and that portion northerly of the railroad trestle in Chuckanut Bay.

Additional coho seasonal closure: During the month of September, closed to gill nets in the waters of Area 7B west of a line from Point Francis (48°41'42"N, 122°36'40"W) to the red and green buoy southeast of Point Francis (48°40'22"N, 122°35'30"W), then to the northernmost tip of Eliza Island (48°39'37"N, 122°35'45"W), then along the eastern shore of the island to a point intersecting a line drawn through Eliza Rock Light (48°38'35"N, 122°34'40"W) and Fish Point (48°34'35"N, 122°29'45"W), and then southeastward along that line to Fish Point. Nontreaty purse seiners fishing in this area must release coho.

Area 7C - That portion southeasterly of a line projected from the mouth of Oyster Creek 237° true to a fishing boundary marker on Samish Island.

Area 8 - (1) That portion of Skagit Bay easterly of a line projected from Brown Point on Camano Island to a white monument on the easterly point of Ika Island, thence across the Skagit River to the terminus of the jetty with McGlinn Island.

(2) Those waters within 1,500 feet of the western shore of Camano Island south of a line projected true west from Rocky Point.

Area 8A - (1) Those waters easterly of a line projected from ((~~Mission Point to Buoy C1, excluding the waters of~~)) Mission Point to Buoy C1, excluding the waters of Area 8D, thence through the green light at the entrance jetty of the Snohomish River and across the mouth of the Snohomish River to landfall on the eastern shore, and those waters northerly of a line from Camano Head to the northern boundary of Area 8D, except when open for pink fisheries.

(2) Additional ((~~pink and~~)) coho seasonal closure prior to October 3: Those waters southerly of a line projected from the Clinton ferry dock to the Mukilteo ferry dock.

(3) Adjusted pink seasonal closure: Those waters easterly of a line projected from the southernmost point of Area 8D, the point of which begins from a line projected 225° from the pilings at Old Bower's Resort to a point 2,000 feet offshore, thence through the green light at the entrance jetty of the Snohomish River and across the mouth of the Snohomish River to landfall on the eastern shore, and those waters northerly of a line from Camano Head to the northern boundary of Area 8D, and waters southerly of a line projected from the Clinton ferry dock to the Mukilteo ferry dock.

Area 8D - Those waters easterly of a line projected from Mission Point to Hermosa Point.

Area 9 - Those waters lying inside and westerly of a line projected from the Point No Point light to Sierra Echo buoy, thence to Forbes Landing wharf east of Hansville.

Area 10 - (1) Those waters easterly of a line projected from Meadow Point to West Point.

(2) Those waters of Port Madison westerly of a line projected from Point Jefferson to the northernmost portion of Point Monroe.

(3) Additional pink seasonal closure: The area east inside of the line originating from West Point and extending west to the closest midchannel buoy, thence true through Point Wells until reaching latitude 47°44'500"N, thence extending directly east to the shoreline.

(4) Additional coho and chum seasonal closure: Those waters of Elliott Bay east of a line from Alki Point to the light at Fourmile Rock, and those waters northerly of a line projected from Point Wells to "SF" Buoy, then west to President's Point.

Area 10E - Those waters of Liberty Bay north of a line projected due east from the southernmost Keyport dock, those waters of Dyes Inlet north of the Manette Bridge, and those waters of Sinclair Inlet southwest of a line projected true east from the Bremerton ferry terminal.

Area 11 - (1) Those waters northerly of a line projected true west from the light at the mouth of Gig Harbor, and those waters south of a line from Browns Point to the northernmost point of land on Point Defiance.

(2) Additional coho seasonal closure: Those waters south of a line projected from the light at the mouth of Gig Harbor to the Tahlequah ferry dock, then south to the Point Defiance ferry dock, and those waters south of a line projected from the Point Defiance ferry dock to Dash Point.

Area 12 - Those waters inside and easterly of a line projected from Lone Rock to the navigation light off Big Beef Creek, thence southerly to the tip of the outermost northern headland of Little Beef Creek.

Area 12A - Those waters north of a line projected due east from Broad Spit.

Area 12B - Those waters within 1/4-mile of the mouths of the Dosewallips, Duckabush, and Hamma Hamma rivers and Anderson Creek.

Areas 12, 12A, and 12B - (1) Those waters within 1,000 feet of the mouth of the Quilcene River.

(2) Additional Chinook seasonal closure: Those waters north and east of a line projected from Tekiu Point to Triton Head.

Areas 12, 12B and 12C - Those waters within 1,000 feet of the eastern shore.

Area 12C - (1) Those waters within 2,000 feet of the western shore between the dock at Glen Ayr R.V. Park and the Hoodsport marina dock.

(2) Those waters south of a line projected from the Cushman Powerhouse to the public boat ramp at Union.

(3) Those waters within 1/4-mile of the mouth of the Dewatto River.

Areas 12 and 12D - Additional coho and chum seasonal closure: Those waters of Area 12 south and west of a line projected 94 degrees true from Hazel Point to the light on the opposite shore, bounded on the west by the Area 12/12B boundary line, and those waters of Area 12D.

Area 13A - Those waters of Burley Lagoon north of State Route 302; those waters within 1,000 feet of the outer oyster stakes off Minter Creek Bay, including all waters of Minter Creek Bay; those waters westerly of a line drawn due north from Thompson Spit at the mouth of Glen Cove; and those waters within 1/4-mile of Green Point.

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-311 Purse seine—Open periods. It is unlawful to take, fish for, or possess salmon taken with purse seine gear for commercial purposes from Puget Sound, except in the following designated Puget Sound Salmon Management and Catch Reporting Areas and during the periods provided for in each respective Management and Catch Reporting Area:

AREA	TIME		DATE
7, 7A:	7AM - 6PM	-	10/10, 10/11, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31, 11/1, 11/2, 11/3, 11/4, 11/5((~~, 11/6~~))
	7AM - 5PM	-	11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/12((~~, 11/13~~))
Note: In Areas 7 and 7A, it is unlawful to fail to brail when fishing with purse seine gear. Any time brailing is required, purse seine fishers must also use a recovery box in compliance with WAC 220-47-301 (7)(a) through (f).			
7B, 7C:	6AM - 8PM	-	((~~8/18, 8/25, 9/1~~)) 8/17, 8/24, 8/31
7B:	7AM - 8PM	-	((~~9/8~~)) 9/7
	7AM - 7PM	-	((~~9/13, 9/15, 9/17~~)) 9/12, 9/14, 9/16
	7AM ((~~9/19~~)) 9/18	-	6PM ((~~10/30~~)) 10/29
	7AM ((~~11/1~~)) 10/31	-	4PM ((~~11/5~~)) 11/4
	7AM ((~~11/8~~)) 11/7	-	4PM ((~~11/12~~)) 11/11
	7AM ((~~11/15~~)) 11/14	-	4PM ((~~11/19~~)) 11/18
	7AM ((~~11/22~~)) 11/21	-	4PM ((~~11/26~~)) 11/25
	8AM ((~~11/29~~)) 11/28	-	4PM ((~~12/3~~)) 12/2
Note: That portion of Area 7B east of a line from Post Point to the flashing red light at the west entrance to Squalicum Harbor is open to purse seines beginning at 12:01 a.m. on the last Monday in October and until 4:00 p.m. on the first Friday in December.			
8	6AM - 8PM	-	8/22, 8/24, 8/30, 9/1
8A:	6AM - 8PM	-	8/18, 8/23, 8/25, 8/29

AREA	TIME		DATE
	7AM - 7PM	-	Limited participation - two boats (((~~9/27, 10/4).~~)) 9/19, 9/26)
	((~~7AM - 6PM~~	-	~~10/11~~))
8D:	7AM - 7PM	-	((~~9/20, 9/27, 10/4~~)) 9/19, 9/26, 10/3
	7AM - 6PM	-	((~~10/11, 10/18, 10/25, 10/27, 11/3~~)) 10/10, 10/18, 10/24, 10/26, 11/1
	7AM - 5PM	-	((~~11/9, 11/11, 11/17~~)) 11/7, 11/9, 11/15
	7AM - 4PM	-	((~~11/22, 11/24~~)) 11/29
10	6AM - 8PM	-	Limited participation - four boats (8/22, 8/24, 8/30)
10, 11:	7AM - 6PM	-	10/18, 10/24, 10/26, ((~~10/28,~~)) 11/1
	7AM - 5PM	-	11/7, 11/9, ((~~11/11,~~)) 11/15
	7AM - 4PM	-	((~~11/23~~)) 11/22
12, 12B:	7AM - 6PM	-	10/18, 10/24, 10/26, ((~~10/28,~~)) 11/1
	7AM - 5PM	-	11/7, 11/9, ((~~11/11,~~)) 11/15
12C:	7AM - 5PM	-	11/7, 11/9, ((~~11/11,~~)) 11/15
	7AM - 4PM	-	((~~11/23~~)) 11/21

Note: ((~~In Areas 12, 12B, and 12C, it is unlawful to take or fish for salmon during any open period with purse seine gear unless purse seine fishers are using a recovery box in compliance with WAC 220-47-301 (7)(a) through (f).~~)) In Area 10 during any open period occurring in August or September, it is unlawful to fail to brail or use a brailing bunt when fishing with purse seine gear. Any time brailing is required, purse seine fishers must also use a recovery box in compliance with WAC 220-47-301 (7)(a) through (f). During limited participation fisheries it is unlawful for vessels to take or fish for salmon without department observers on board.

It is unlawful to retain the following salmon species taken with purse seine gear within the following areas during the following periods:

Chinook salmon - at all times in Areas 7, 7A, 8, 8A, 8D, 10, 11, 12, 12B, and 12C, and after October ((~~23~~)) 22 in Area 7B.

Coho salmon - at all times in Areas 7, 7A, 10, and 11, and prior to September ((~~5~~)) 4 in Area 7B((~~, and wild coho in Areas 12, 12B, and 12C~~)).

Chum salmon - prior to October 1 in Areas 7 and 7A, and at all times in 8A.

All other saltwater and freshwater areas - closed.

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-401 Reef net open periods. (1) It is unlawful to take, fish for, or possess salmon taken with reef net gear for commercial purposes in Puget Sound, except in the following designated Puget Sound Salmon Management and Catch Reporting Areas, during the periods provided for in each respective area:

AREA	TIME	DATE(S)
7, 7A	5AM - 9PM Daily	((~~9/12~~)) 10/2 - 11/13

(2) It is unlawful at all times to retain wild Chinook salmon taken with reef net gear, and it is unlawful prior to October 1 to retain chum or wild coho salmon taken with reef net gear.

(3) It is unlawful to retain marked Chinook after September 30.

(a) It is unlawful to retain marked Chinook with reef net gear if the fisher does not have in his or her immediate possession a department-issued Puget Sound Reef Net Logbook with all retained Chinook accounted for in logbook. Marked Chinook are those with a clipped adipose fin and a healed scar at the site of the clipped fin.

(b) Completed logs must be submitted and received within six working days to: Puget Sound Commercial Salmon Manager, Department of Fish & Wildlife, 600 Capitol Way N, Olympia WA, 98501-1091.

(4) All other saltwater and freshwater areas - closed.

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-411 Gill net—Open periods. It is unlawful to take, fish for, or possess salmon taken with gill net gear for commercial purposes from Puget Sound, except in the following designated Puget Sound Salmon Management and Catch Reporting Areas during the periods provided for in each respective fishing area:

AREA	TIME			DATE(S)	MINIMUM MESH
6D: Skiff gill net only, definition WAC 220-16-046 and lawful gear description WAC 220-47-302.	7AM	-	7PM	9/21, 9/22, 9/23, ((~~9/24~~)) 9/26, 9/27, 9/28, 9/29, 9/30, ((~~10/1~~)) 10/3, 10/4, 10/5, 10/6, 10/7, ((~~10/8~~)) 10/10, 10/11, 10/12, 10/13, ((~~10/14, 10/15~~)) 10/17, 10/18, 10/19, 10/20, 10/21 ((~~, 10/22~~))	5"

Note: In Area 6D, it is unlawful to use other than 5-inch minimum mesh in the skiff gill net fishery. It is unlawful to retain Chinook taken in Area 6D at any time, or any chum salmon taken in Area 6D prior to October 16. In Area 6D, any Chinook or chum salmon required to be released must be removed from the net by cutting the meshes ensnaring the fish.

7, 7A:	7AM	-	Midnight; use of recovery box required	10/10, 10/11, 10/14, 10/15	6 1/4"
	7AM	-	Midnight	10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31, 11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/12((~~, 11/13~~))	6 1/4"

AREA	TIME			DATE(S)	MINIMUM MESH
Note: In Areas 7 and 7A after ((~~September 26~~)) October 9 but prior to October ((~~17~~)) 16, coho and Chinook salmon must be released, and it is unlawful to use a net soak time of more than 45 minutes. Net soak time is defined as the time elapsed from when the first of the gill net web enters the water, until the gill net is fully retrieved from the water. Fishers must also use a recovery box in compliance with WAC 220-47-302 (5)(a) through (f).					
7B, 7C:	7PM	-	8AM	NIGHTLY ((~~8/15, 8/17, 8/18, 8/22, 8/24, 8/25, 8/29, 8/31, 9/1~~)) 8/14, 8/16, 8/17, 8/21, 8/22, 8/23, 8/24, 8/28, 8/30, 8/31	7"
7B:	7AM	-	7 AM the day following	9/4, 9/5, 9/6, 9/7, 9/8, ((~~9/9~~)) 9/11, 9/12, 9/13, 9/14, ((~~9/16~~)) 9/15	5"
	7AM ((~~9/19~~)) 9/18	-	Midnight ((~~10/23~~)) 10/22		5"
	12:01AM ((~~10/24~~)) 10/23	-	Midnight ((~~10/30~~)) 10/29		6 1/4"
	7AM ((~~11/1~~)) 10/31	-	4PM ((~~11/5~~)) 11/4		6 1/4"
	6AM ((~~11/8~~)) 11/7	-	4PM ((~~11/12~~)) 11/11		6 1/4"
	6AM ((~~11/15~~)) 11/14	-	4PM ((~~11/19~~)) 11/18		6 1/4"
	7AM ((~~11/22~~)) 11/21	-	4PM ((~~11/26~~)) 11/25		6 1/4"
	8AM ((~~11/29~~)) 11/28	-	4PM ((~~12/3~~)) 12/2		6 1/4"
Note: That portion of Area 7B east of a line from Post Point to the flashing red light at the west entrance to Squalicum Harbor is open to gill nets using 6 1/4-inch minimum mesh beginning 12:01 AM on the last day in October and until 4:00 PM on the first Friday in December.					
8:	5AM	-	11PM	8/23, 8/25	5" minimum and 5 1/2" maximum
	5:30AM	-	11PM	8/29, 8/31	5" minimum and 5 1/2" maximum
Note: In Area 8 it is unlawful to take or fish for pink salmon with drift gill nets greater than 60 mesh maximum depth.					
8A:	5AM	-	11:30PM	8/17	5" minimum and 5 1/2" maximum
	5AM	-	11PM	8/22, 8/24	5" minimum and 5 1/2" maximum
	5:30AM	-	11PM	8/31	5" minimum and 5 1/2" maximum
((~~8A.~~))	6PM	-	8AM	NIGHTLY ((~~10/4~~)) 9/27, 9/28	5"
	((~~7AM~~	~~-~~	~~8PM~~	~~10/12, 10/13, 10/14~~	~~5"~~))
8D:	6PM	-	8AM	NIGHTLY 9/18, 9/19, 9/20, 9/21, 9/22, ((~~9/23~~)) 9/25, 9/26, 9/27, 9/28, 9/29, ((~~9/30~~)) 10/2, 10/3, 10/4, 10/5, 10/6((~~, 10/7~~))	5"
	5PM	-	8AM	10/9, 10/10, 10/11, 10/12, 10/13((~~, 10/14~~))	5"
	5PM	-	9AM	10/16, 10/17, 10/18, 10/19, 10/20, 10/23, 10/24, 10/25, 10/26, 10/27, 10/30, 10/31, 11/1, 11/2, 11/3	5"
	7AM	-	9PM	9/20, 9/21, ((~~9/22~~)) 9/27, 9/28, ((~~9/29~~)) 10/4, 10/5((~~, 10/6~~))	5"
	7AM	-	8PM	10/11, 10/12, ((~~10/13, 10/21, 10/28, 11/4~~)) 10/18, 10/19, 10/25, 10/26, 11/1, 11/2	5"
	((~~7AM~~	~~-~~	~~4PM~~	~~10/22, 10/29, 11/5~~	~~5"~~))
	6AM	-	6PM	((~~11/10, 11/18~~)) 11/9, 11/10, 11/16, 11/17	6 1/4"
	7AM	-	6PM	((~~11/25~~)) 11/23, 11/24	6 1/4"
	6AM	-	4PM	((~~11/12, 11/19~~)) 11/11, 11/18	6 1/4"
	7AM	-	4PM	((~~11/26~~)) 11/25	6 1/4"

AREA	TIME			DATE(S)	MINIMUM MESH
9A: Skiff gill net only, definition WAC 220-16-046 and lawful gear description WAC 220-47-302.	7AM 8/21	-	7PM 10/29	((~~8/22 through 10/30 daily~~))	5"
Note: It is unlawful to retain chum salmon taken in Area 9A prior to October 1, and it is unlawful to retain Chinook salmon at any time. Any salmon required to be released must be removed from the net by cutting the meshes ensnaring the fish.					
10	5AM	-	11PM	Limited participation - four boats (8/23, 8/25)	4 1/2" minimum and 5 1/2" maximum
	5:30AM	-	11PM	Limited participation - four boats (8/30)	4 1/2" minimum and 5 1/2" maximum
Note: In Area 10 during August or September openings coho and Chinook salmon must be released, and it is unlawful to use a net soak time of more than 45 minutes. Net soak time is defined as the time elapsed from when the first of the gill net web enters the water, until the gill net is fully retrieved from the water. Fishers must also use a recovery box in compliance with WAC 220-47-302 (5)(a) through (f). During all limited participation fisheries it is unlawful for vessels to take or fish for salmon without department observers on board.					
10, 11:	5PM	-	9AM	NIGHTLY ((~~10/19, 10/24, 11/2~~)) 10/16, 10/27, 10/30	6 1/4"
	5PM	-	8AM	NIGHTLY ((~~10/27~~)) 10/25	6 1/4"
	4PM	-	8AM	NIGHTLY ((~~11/7~~)) 11/8, 11/10, ((~~11/16~~)) 11/13	6 1/4"
	3PM	-	8AM	NIGHTLY ((~~11/21~~)) 11/20	6 1/4"
	4PM	-	Midnight	NIGHTLY ((~~10/20, 11/3, 11/17, 11/24~~)) 10/19, 11/2, 11/16, 11/23	6 1/4"
12A: Skiff gill net only, definition WAC 220-16-046 and lawful gear description WAC 220-47-302.	7AM	-	7PM	Dates determined per agreement with tribal comanagers in-season if Summer Chum Salmon Conservation Initiative goals are met allowing for openings of gill net gear.	5"
Note: In Area 12A, it is unlawful to use other than 5-inch minimum mesh in the skiff gill net fishery. It is unlawful to retain Chinook or chum salmon taken in Area 12A at any time, and any salmon required to be released must be removed from the net by cutting the meshes ensnaring the fish.					
12, 12B:	7AM	-	8PM	10/17, 10/19, ((~~10/21,~~)) 10/25, 10/27, 10/31, 11/2((~~, 11/4~~))	6 1/4"
	6AM	-	6PM	11/8, 11/10, 11/14, 11/16((~~, 11/18~~))	6 1/4"
12C:	6AM	-	6PM	11/8, 11/10, 11/14, 11/16((~~, 11/18~~))	6 1/4"
	7AM	-	6PM	11/22, ((~~11/25~~)) 11/24	6 1/4"
All other saltwater and freshwater areas - closed.					
Nightly openings refer to the start date.					
Within an area or areas, a mesh size restriction remains in effect from the first date indicated until a mesh size change is shown, and the new mesh size restriction remains in effect until changed.					

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-427 Puget Sound—Beach seine—Emerging commercial fishery—Eligibility—Lawful gear. (1) The Puget Sound beach seine salmon fishery is designated as an emerging commercial fishery for which a vessel is required. An emerging commercial fishery license and an experimental fishery permit are required to participate in this fishery.

(2) The department will issue four salmon beach seine experimental fishery permits.

(3) The following is the selection process the department will use to offer a salmon beach seine experimental permit.

(a) Persons who held a salmon beach seine experimental fishery permit in the previous management year will be eligible for a permit in the current management year.

(b) The department ((~~established a pool of applicants by drawing on August 13, 2002~~)) will work with the advisory board, per RCW 77.70.160(1), to establish criteria by which applicants would qualify to enter the pool. The pool established by this drawing will be maintained to replace any permit(s) which may be voided.

(4) Permit holders are required to participate in the salmon beach seine experimental fishery.

(a) For purposes of this section, "participation" means the holder of the salmon beach seine experimental permit being aboard the designated vessel in the open fishery.

(b) If the salmon beach seine experimental permit holder fails to participate, the salmon beach seine experimental permit issued to that fisher will be void and a new salmon beach seine experimental permit will be issued through a random drawing from the applicant pool ((~~established in 2002~~)).

(c) The department may require proof of participation by maintaining a department approved log book or registering with state officials each day the salmon beach seine experimental permit holder participates.

(d) Persons who participate, but violate conditions of a salmon beach seine experimental permit, will have the permit voided and a new salmon beach seine experimental permit

will be reissued through a random drawing from the pool of the voided permit holder.

(5) In Quilcene Bay, chum salmon may not be retained by a salmon beach seine experimental permit holder. Chum salmon in Quilcene Bay must be released alive.

(6) Any person who fails to purchase the license, fails to participate, or violates the conditions of a salmon beach seine experimental permit will have his or her name permanently withdrawn from the pools.

(7) It is unlawful to take salmon with beach seine gear that does not meet the requirements of this subsection.

(a) Beach seine salmon nets in Puget Sound shall not exceed 600 feet in length or 100 meshes in depth, or contain meshes of a size less than 3 inches or greater than 4 inches.

(b) Mesh webbing must be constructed with a twine size no smaller than 210/30d nylon, 12 thread cotton, or the equivalent diameter in any other material.

AMENDATORY SECTION (Amending Order 10-137, filed 7/7/10, effective 8/7/10)

WAC 220-47-428 Beach seine—Open periods. It is unlawful to take, fish for, or possess salmon taken with beach seine gear for commercial purposes from Puget Sound except in the following designated Puget Sound Salmon Management and Catch Reporting Areas during the periods provided hereinafter in each respective Management and Catch Reporting Area:

All areas:

AREA	TIME			DATE(S)
12A:	7AM	-	7PM	8/22, 8/23, 8/24, 8/25, 8/26, 8/29, 8/30, 8/31, 9/1, 9/2, 9/5, 9/6, 9/7, 9/8, 9/9, 9/12, 9/13, 9/14, 9/15, 9/16, 9/19, 9/20, 9/21, 9/22, 9/23, 9/26, 9/27, 9/28, 9/29, 9/30
12H:	7AM	-	7PM	November (dates determined per agreement with tribal comanagers in-season if harvestable surplus of salmon remain).

It is unlawful to retain Chinook taken with beach seine gear in all areas, and unlawful to retain chum from Area 12A.

WSR 11-16-028
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed July 27, 2011, 8:02 a.m., effective August 27, 2011]

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

Purpose: The department is amending WAC 388-406-0060 What happens when my application is denied?

The amendments amend subsection (1)(b) of this rule which describes when an application is denied for lack of information. Subsection (1)(b) incorrectly references WAC 388-414-0001 Do I have to meet all eligibility requirements for Basic Food? This reference should be changed to WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food. Application processing rules are based on federal regulations. These changes are necessary to align application processing rules with federal regulations.

Citation of Existing Rules Affected by this Order: Amending WAC 388-406-0060.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090.

Adopted under notice filed as WSR 11-11-093 on May 18, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 1, 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 1, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: July 25, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-22-039, filed 10/28/03, effective 12/1/03)

WAC 388-406-0060 What happens when my application is denied? (1) We (the department) deny your application for cash, medical, or Basic Food benefits if:

(a) You do not show for your interview appointment for cash or Basic Food if required under WAC 388-452-0005, you have not rescheduled, and your application is over thirty days old; or

(b) We do not have the information we need to determine your eligibility within ten days of requesting the information from your assistance unit (AU) under WAC ((~~388-414-0001~~)) 388-490-0005, and you did not ask for additional time to give us the information; or

(c) Your entire AU does not meet certain eligibility criteria to get benefits; or

(d) For Basic Food, your application has not been processed by the sixtieth day because of a delay on your part.

(2) If we deny your application, you do not get benefits unless:

(a) You mistakenly apply for benefits you already get; or

(b) We reconsider your eligibility under WAC 388-406-0065 and you are eligible to get benefits.

(3) We can reconsider if you are eligible for benefits under the requirements of WAC 388-406-0065 even after your application is denied.

(4) We give or send a letter to you explaining why your application was denied as required under WAC 388-458-0011.

(5) If you disagree with our decision about your application, you can ask for a fair hearing. If we deny your application because we do not have enough information to decide that you are eligible, the hearing issue is whether you are eligible using:

(a) Information we already have; and

(b) Any more information you can give us.

WSR 11-16-029
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed July 27, 2011, 8:04 a.m., effective August 27, 2011]

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

Purpose: The department is reducing payment standards and maximum earned income limits by fifteen percent. This reduction is necessary 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.

These changes are currently in effect via emergency adoption as WSR 11-11-009 dated May 6, 2011.

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

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, 74.08.090, and chapters 74.08A and 74.12 RCW.

Adopted under notice filed as WSR 11-11-094 on May 18, 2011.

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 3, 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 3, Amended 0, Repealed 0.

Date Adopted: July 25, 2011.

Katherine I. Vasquez
Rules Coordinator

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:

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

(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

	1	2	3	4	5	6	7	8 or more
Utilities	((~~89~~))	((~~113~~))	((~~140~~))	((~~164~~))	((~~189~~))	((~~216~~))	((~~250~~))	((~~276~~))
	76	96	119	139	161	184	213	235
Household maintenance	((~~65~~))	((~~83~~))	((~~103~~))	((~~121~~))	((~~140~~))	((~~159~~))	((~~183~~))	((~~202~~))
	55	71	88	103	119	135	156	172
Job related transportation	((~~359~~))	((~~453~~))	((~~562~~))	((~~661~~))	((~~762~~))	((~~866~~))	((~~1000~~))	((~~1107~~))
	305	385	478	562	648	736	850	941
Child related transportation	((~~359~~))	((~~453~~))	((~~562~~))	((~~661~~))	((~~762~~))	((~~866~~))	((~~1000~~))	((~~1107~~))
	305	385	478	562	648	736	850	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 maximum monthly 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 maximum monthly 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 Monthly 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 11-16-030
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed July 27, 2011, 8:05 a.m., effective August 27, 2011]

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

Purpose: The department is amending WAC 388-416-0005 How long can I get Basic Food?

This change extends the certification period for a Basic Food assistance unit (AU) from up to six months to up to twelve months if the AU:

- Includes a nonexempt able-bodied adult without dependents;
- Receives services under the Alcohol and Drug Addiction Treatment and Support Act;
- Is homeless; or
- Is a migrant or seasonal farmworker.

These amendments allow all Basic Food AUs that are not receiving benefits under the Washington state combined application project (WASHCAP) to have a consistent certification period of up to twelve months.

Citation of Existing Rules Affected by this Order: Amending WAC 388-416-0005.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, and 74.08.090.

Adopted under notice filed as WSR 11-11-090 on May 18, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 1, 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 1, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: July 21, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-07-007, filed 3/4/10, effective 4/4/10)

WAC 388-416-0005 How long can I get Basic Food? (1) The length of time the department determines your assistance unit (AU) is eligible to get Basic Food is called a certification period. The department may certify your AU for up to twelve months, unless:

(a) ((**~~Six months~~** ~~if your AU:~~

~~(i) Includes an able-bodied adult without dependents (ABAWD) who receives Basic Food in your AU and your AU does not live in an exempt area as described in WAC 388-444-0030;~~

~~(ii) Includes a person who receives ADATSA benefits as described in chapter 388-800 WAC;~~

~~(iii) Is considered homeless under WAC 388-408-0050; or~~

~~(iv) Includes a migrant or seasonal farmworker as described under WAC 388-406-0021.~~

~~(b) **Twelve months** if your AU does not meet any of the conditions for six months.~~

~~(2) If~~)) You receive food assistance under WASHCAP, we set your certification period as described under WAC 388-492-0090.

(b) You receive transitional food assistance, we set your certification period as described under WAC 388-489-0015.

(((~~(3) If your AU is homeless **or** includes an ABAWD when you live in a nonexempt area, we may shorten your certification period.~~))

(((~~(4)~~))) (2) We terminate your Basic Food benefits ((~~when~~)) before the end of your certification period in subsection (1) if:

(a) You fail to complete a mid-certification review as described under WAC 388-418-0011;

(b) We get proof of a change that makes your AU ineligible; or

(((~~(b)~~))) (c) We get information that your AU is ineligible((~~,~~)) and

(((~~(c)~~))) you do not provide needed information to verify your AU's circumstances.

WSR 11-16-031
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2011-07—Filed July 27, 2011, 9:51 a.m., effective August 27, 2011]

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

Purpose: The rule amends WAC 284-29A-030 to postpone by one year the date upon which title insurers must file their rates with the commissioner under RCW 48.29.147 and when rate filings must be made under RCW 48.29.147 rather than RCW 48.29.140.

Citation of Existing Rules Affected by this Order: Amending WAC 284-29A-030.

Statutory Authority for Adoption: RCW 48.02.060 and 48.29.140.

Adopted under notice filed as WSR 11-13-126 on June 22, 2011.

A final cost-benefit analysis is available by contacting Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7036, fax (360) 586-3109, e-mail jimt@oic.wa.gov.

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

ing: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: July 27, 2011.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2009-01, filed 7/20/10, effective 8/20/10)

WAC 284-29A-030 Transition to prior approval system. (1) On and after January 1, ((~~2012~~)) 2013, all rates used in Washington state must be filed and approved under RCW 48.29.147.

(2) Title insurers must submit the rate filings required under RCW 48.29.147 and subsection (1) of this section to the commissioner by September 1, ((~~2011~~)) 2012, for rates to be effective on January 1, ((~~2012~~)) 2013. This rule allows the commissioner time to take final action on rates filed under this chapter before the effective date of January 1, ((~~2012~~)) 2013.

(3) Rates filed under RCW 48.29.140(2) must not be used for commitments issued on or after January 1, ((~~2012~~)) 2013.

WSR 11-16-041
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed July 27, 2011, 2:59 p.m., effective August 27, 2011]

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

Purpose: Chapter 246-470 WAC establishes a prescription monitoring program (PMP). The rules are in response to 2007 legislation (ESSSB [E2SSB] 5930) which requires the department to implement a PMP, subject to available funding. The rule establishes definitions for terms used throughout the chapter, and requirements for adding additional drugs, dispenser data submission, accessing information from the program, confidentiality, and penalties and sanctions.

Statutory Authority for Adoption: Chapter 70.225 RCW, ESSSB [E2SSB] 5930 (chapter 259, Laws of 2007).

Adopted under notice filed as WSR 11-11-097 on May 18, 2011.

Changes Other than Editing from Proposed to Adopted Version: Two minor changes were made to address grammatical errors in WAC 246-470-050. Properly using the word "or" instead of "and."

A final cost-benefit analysis is available by contacting John Hilger, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-2929, fax (360) 236-2901, e-mail john.hilger@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 11, 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 11, Amended 0, Repealed 0.

Date Adopted: July 27, 2011.

Mary C. Selecky
Secretary

Chapter 246-470 WAC

PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-470-001 Purpose. These rules implement the prescription monitoring program, established by the legislature in chapter 70.225 RCW, as a means to promote the public health, safety, and welfare and to detect and prevent prescription drug abuse.

NEW SECTION

WAC 246-470-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly indicates otherwise:

(1) "Authentication" means information, electronic device, or certificate provided by the department or their designee to a data requestor to electronically access prescription monitoring information. The authentication may include, but is not limited to, a user name, password, or an identification electronic device or certificate.

(2) "Controlled substance" has the same meaning provided in RCW 69.50.101.

(3) "Department" means the department of health.

(4) "Dispenser" means a practitioner or pharmacy that delivers to the ultimate user a schedule II, III, IV, or V controlled substance or other drugs identified by the board of pharmacy in WAC 246-470-020, but does not include:

(a) A practitioner or other authorized person who only administers, as defined in RCW 69.41.010, a controlled substance or other drugs identified by the board of pharmacy in WAC 246-470-020; or

(b) A licensed wholesale distributor or manufacturer, as defined in chapter 18.64 RCW, of a controlled substance or other drugs identified by the board of pharmacy in WAC 246-470-020.

(5) "Patient" means the person or animal who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

(6) "Patient address" means the current geographic location of the patient's residence. If the patient address is in care of another person or entity, the address of that person or entity is the "patient address" of record. When alternate addresses are possible, they must be recorded in the following order of preference:

(a) The geographical location of the residence, as would be identified when a telephone is used to place a 9-1-1 call; or

(b) An address as listed by the United States Postal Service; or

(c) The common name of the residence and town.

(7) "Pharmacist" means a person licensed to engage in the practice of pharmacy.

(8) "Prescriber" means a licensed health care professional with authority to prescribe controlled substances.

(9) "Prescription monitoring information" means information submitted to and maintained by the prescription monitoring program.

(10) "Program" means the prescription monitoring program established under chapter 70.225 RCW.

(11) "Valid photographic identification" means:

(a) A driver's license or instruction permit issued by any United States state or province of Canada. If the patient's driver's license has expired, the patient must also show a valid temporary driver's license with the expired card.

(b) A state identification card issued by any United States state or province of Canada.

(c) An official passport issued by any nation.

(d) A United States armed forces identification card issued to active duty, reserve, and retired personnel and the personnel's dependents.

(e) A merchant marine identification card issued by the United States Coast Guard.

(f) A state liquor control identification card. An official age identification card issued by the liquor control authority of any United States state or Canadian province.

(g) An enrollment card issued by the governing authority of a federally recognized Indian tribe located in Washington, if the enrollment card incorporates security features comparable to those implemented by the department of licensing for Washington drivers' licenses and are recognized by the liquor control board.

NEW SECTION

WAC 246-470-020 Adding additional drugs to the program. Pursuant to RCW 70.225.020, the board of pharmacy may add additional drugs to the list of drugs being monitored by the program by requesting the department amend these rules.

NEW SECTION

WAC 246-470-030 Data submission requirements for dispensers. A dispenser shall provide to the department the dispensing information required by RCW 70.225.020 and this section for all scheduled II, III, IV, and V controlled substances and for drugs identified by the board of pharmacy pursuant to WAC 246-470-020.

(1) Dispenser identification number. A dispenser shall acquire and maintain an identification number issued to dispensing pharmacies by the National Council for Prescription Drug Programs or a prescriber identifier issued to authorized prescribers of controlled substances by the Drug Enforcement Administration, United States Department of Justice.

(2) Submitting data. A dispenser shall submit data to the department electronically, not later than one week from the date of dispensing, and in the format required by the department.

(a) A dispenser shall submit for each dispensing the following information and any additional information required by the department:

(i) Patient identifier. A patient identifier is the unique identifier assigned to a particular patient by the dispenser;

(ii) Name of the patient for whom the prescription is ordered including first name, middle initial, last name, and generational suffixes, if any;

(iii) Patient date of birth;

(iv) Patient address;

(v) Patient gender;

(vi) Drug dispensed;

(vii) Date of dispensing;

(viii) Quantity and days supply dispensed;

(ix) Refill information;

(x) Prescriber identifier;

(xi) Prescription issued date;

(xii) Dispenser identifier;

(xiii) Prescription fill date and number;

(xiv) Source of payment indicated by one of the following:

(A) Private pay (cash, change, credit card, check);

(B) Medicaid;

(C) Medicare;

(D) Commercial insurance;

(E) Military installations and veterans affairs;

(F) Workers compensation;

(G) Indian nations;

(H) Other; and

(xv) When practicable, the name of person picking up or dropping off the prescription, as verified by valid photographic identification.

(b) A nonresident, licensed pharmacy that delivers controlled substances, as defined in RCW 18.64.360, is required to submit only the transactions for patients with a Washington state zip code.

(c) Data submission requirements do not apply to:

(i) The department of corrections or pharmacies operated by a county for the purpose of providing medications to offenders in state or county correctional institutions who are receiving pharmaceutical services from a state or county correctional institution's pharmacy. A state or county correctional institution's pharmacy must submit data to the program related to each offender's current prescriptions for controlled substances upon the offender's release from a state or county correctional institution.

(ii) Medications provided to patients receiving inpatient services provided at hospitals licensed under chapter 70.41 RCW or patients of such hospitals receiving services at the clinics, day surgery areas, or other settings within the hospital's license where the medications are administered in single doses; or medications provided to patients receiving outpatient services provided at ambulatory surgical facilities licensed under chapter 70.230 RCW.

NEW SECTION

WAC 246-470-040 Patient access to information from the program. A patient, or a patient's personal representative authorized under Title 11 RCW (Probate and trust

law) and Title 7 RCW (Special proceedings and actions), may obtain a report listing all prescription monitoring information that pertains to the patient.

(1) Procedure for obtaining information. A patient or a patient's personal representative requesting information pursuant to this section shall submit a written request in person at the department, or at any other place specified by the department. The written request must be in a format established by the department.

(2) Identification required. The patient or the patient's personal representative must provide valid photographic identification prior to obtaining access to the information requested in this section.

(3) Proof of personal representation. Before obtaining access to the information pursuant to this section, a personal representative shall provide either:

(a) An official attested copy of the judicial order granting them authority to gain access to the health care records of the patient;

(b) In the case of parents of a minor child, a certified copy of the birth certificate of the minor child or other certified legal documents establishing parentage or guardianship; or

(c) In the case of persons holding power of attorney, the original document establishing the power of attorney.

The department may verify the patient authorization by any reasonable means prior to providing the information to the patient's personal representative.

NEW SECTION

WAC 246-470-050 Pharmacist, prescriber or other health care practitioner access to information from the program. A pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber may obtain prescription monitoring information relating to their patients, for the purpose of providing medical or pharmaceutical care.

(1) Registration for access. A pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber shall register with the department in order to receive an authentication to access the electronic system. The registration process shall be established by the department.

(2) Verification by the department. The department shall verify the authentication and identity of the pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber before allowing access to any prescription monitoring information.

(3) Procedure for accessing prescription information. A pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber may access information from the program electronically, using the authentication issued by the department.

(4) A pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber may alternately submit a written request via mail or facsimile transmission in a manner and format established by the department.

(5) Reporting lost or stolen authentication. If the authentication issued by the department is lost, missing, or the security of the authentication is compromised, the pharmacist, prescriber, or licensed health care practitioner authorized by a prescriber shall notify the department by telephone and in writing as soon as reasonably possible.

(6) All requests for, uses of, and disclosures of prescription monitoring information by authorized persons must be consistent with the program's mandate as outlined in RCW 70.225.040 and this chapter.

NEW SECTION

WAC 246-470-060 Law enforcement, prosecutorial officials, coroners, and medical examiners' access to information from the program. Local, state, or federal law enforcement officers and prosecutorial officials may obtain prescription monitoring information for a bona fide specific investigation involving a designated person. A local, state, or federal coroner or medical examiner may obtain prescription monitoring information for a bona fide specific investigation to determine cause of death.

(1) Registration for access. Local, state, or federal law enforcement officers, prosecutorial officials, coroners, and medical examiners shall register with the department in order to receive an authentication to access information from the program. The registration process shall be established by the department.

(2) Verification by the department. The department shall verify the authentication and identity of local, state, or federal law enforcement officers, prosecutorial officials, coroners, and medical examiners before allowing access to any prescription monitoring information.

(3) Procedure for accessing prescription information. Local, state, or federal law enforcement officers, prosecutorial officials, coroners and medical examiners may access information from the program electronically using the authentication issued by the department.

(4) Local, state, or federal law enforcement officers and prosecutorial officials shall electronically attest that the requested information is required for a bona fide specific investigation involving a designated person prior to accessing prescription monitoring information.

(5) Local, state, or federal coroner or medical examiners shall electronically attest that the requested information is required for a bona fide specific investigation to determine cause of death prior to accessing prescription monitoring information.

(6) Local, state, or federal law enforcement officers, prosecutorial officials, coroners and medical examiners may alternately submit a written request via mail or facsimile transmission in a format established by the department. The written request must contain an attestation that the requested information is required for a bona fide specific investigation involving a designated person or for a bona fide specific investigation to determine cause of death.

(7) Reporting lost or stolen authentication. If the authentication issued by the department is lost, missing, or the security of the authentication is compromised, the local, state, and federal law enforcement officers, prosecutorial officials, coroners or medical examiners shall notify the department by telephone and in writing as soon as reasonably possible.

(8) All requests for, uses of, and disclosures of prescription monitoring information by authorized persons must be

consistent with the program's mandate as outlined in RCW 70.225.040 and this chapter.

NEW SECTION

WAC 246-470-070 Other prescription monitoring program's access to information from the program. Established prescription monitoring programs may obtain prescription monitoring information for requests from within their jurisdiction that do not violate the provisions of this chapter or chapter 70.225 RCW.

(1) The other prescription monitoring program must provide substantially similar protections for patient information as the protections provided in chapter 70.225 RCW.

(2) The department may share information with other prescription monitoring programs qualified under this section through a clearinghouse or prescription monitoring program information exchange that meets federal health care information privacy requirements.

(3) All requests for, uses of, and disclosures of prescription monitoring information by authorized persons must be consistent with the program's mandate as outlined in RCW 70.225.040 and this chapter.

NEW SECTION

WAC 246-470-080 Access by public or private research entities to information from the program. (1) The department may provide prescription monitoring information in a format established by the department to any public or private entity for statistical, research, or educational purposes.

(2) Before the department releases any requested information, the department shall remove information that could be used to identify individual patients, dispensers, prescribers, and persons who received prescriptions from dispensers.

(3) To obtain information from the program a public or private entity shall submit a request in a format established by the department.

(4) All requests for, uses of, and disclosures of prescription monitoring information by the requesting entity must be consistent with the program's mandate as outlined in RCW 70.225.040 and this chapter.

NEW SECTION

WAC 246-470-090 Confidentiality. Under RCW 70.225.040, prescription monitoring information is confidential, and maintained in compliance with chapter 70.02 RCW and federal health care information privacy requirements.

NEW SECTION

WAC 246-470-100 Penalties and sanctions. In addition to the penalties described in RCW 70.225.060, if the department determines a person has intentionally or knowingly used or disclosed prescription monitoring information in violation of chapter 70.225 RCW, the department may take action including, but not limited to:

(1) Terminating access to the program;

(2) Filing a complaint with appropriate health profession regulatory entities; or

(3) Reporting the violation to law enforcement.

WSR 11-16-042
PERMANENT RULES
DEPARTMENT OF HEALTH
(Nursing Care Quality Assurance Commission)
[Filed July 27, 2011, 3:01 p.m., effective August 27, 2011]

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

Purpose: WAC 246-841-530 through 246-841-585 establishes alternative program requirements for home care aides-certified and medical assistants-certified to meet the nursing assistant certification level of training. The rules outline the requirements for development of the program and requirements for graduates applying for nursing assistant certification.

Statutory Authority for Adoption: RCW 18.88A.087.

Other Authority: RCW 18.88A.060.

Adopted under notice filed as WSR 11-11-047 on May 13, 2011.

A final cost-benefit analysis is available by contacting Terry J. West, Department of Health, P.O. Box 47864, Olympia, WA 98504, phone (360) 236-4712, fax (360) 236-4738, e-mail terry.west@doh.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 11, 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 11, Amended 0, Repealed 0.

Date Adopted: June 21, 2011.

Paula R. Meyer, MSN, RN
Executive Director

NEW SECTION

WAC 246-841-530 Alternative program—Purpose. The commission intends to establish criteria for an alternative program for home care aid-certified and medical assistant-certified that will provide continued opportunity for recruitment and career advancement in nursing, recognize relevant training, and maintain a single standard for competency.

The alternative program is intended to provide twenty-four hours of additional training, including clinical training, on topics not addressed in the specified training for certification as a home care aide or medical assistant, that will meet

the requirements necessary to take the nursing assistant-certified competency evaluation.

Successful completion of an approved alternative program may allow the home care aide-certified and medical assistant-certified to meet requirements to complete a competency evaluation. Successful completion of the competency evaluation may allow an applicant who is a home care aide-certified or medical assistant-certified to become a nursing assistant-certified. The nursing assistant-certified credential may then qualify an individual for entry into a nursing program.

NEW SECTION

WAC 246-841-535 Alternative program—Definitions. The definitions in this section apply throughout WAC 246-841-530 through 246-841-585.

(1) **Home care aide-certified** means any person certified under chapter 18.88B RCW.

(2) **Medical assistant-certified** means a person certified by a medical assistant program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the American Association of Medical Assistants and the American Medical Association.

(3) **Nursing assistant-certified** means any person certified under chapter 18.88A RCW.

NEW SECTION

WAC 246-841-545 Home care aide-certified alternative program requirements. The commission may approve alternative programs for individuals credentialed as home care aides-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

(1) An alternative program shall:

(a) Meet the requirements of WAC 246-841-420.

(b) Have a competency based curriculum composed of learning objectives and activities. The curriculum content shall include:

(i) Measuring vital signs, height and weight, fluid and food input and output.

(ii) Developmental tasks associated with developmental and age specific processes.

(iii) Use and care of prosthetic devices.

(iv) Provision of adequate ventilation, warmth, light, and quiet for the client.

(v) Principles of good body mechanics for self and clients to lift and move clients or heavy items.

(vi) Achieving competence in reading, writing, speaking and understanding English at the level necessary to:

(A) Use terminology accepted in health care settings.

(B) Accurately record and report observations, actions and information in a timely manner.

(vii) The scope of practice of nursing assistant-certified.

(viii) The workers right to know law.

(ix) The Uniform Disciplinary Act, including RCW 18.130.180.

(c) Have a program director:

(i) Who is currently licensed as a registered nurse (RN) in good standing in the state of Washington and has a minimum of three years of experience as an RN with at least one year of experience in direct patient care; and

(ii) Who has successfully completed a training course on adult instruction or can demonstrate that he or she has one year experience teaching adults, unless the program director works exclusively in a secondary educational setting.

(A) The training course on adult instruction must provide instruction in understanding the adult learner, techniques for teaching adults, classroom methods for teaching adults and audio-visual techniques for teaching adults.

(B) Acceptable experience does not include in-service education or patient teaching.

(iii) Who has a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age or both if also acting as an instructor.

(2) The program director may select instructional staff to assist in the teaching of the course. Instructional staff must meet the following requirements:

(a) Hold a current Washington state license to practice as a registered or licensed practical nurse in good standing; and (b) Have a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age.

(3) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor must be under the supervision of the program director at all times.

(4) A guest lecturer or individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content. The guest lecturer, where applicable, must hold a license, certificate or registration in good standing in their field of expertise.

NEW SECTION

WAC 246-841-550 Medical assistant-certified alternative program requirements. The commission may approve alternative programs for individual medical assistant-certified to successfully complete in order to qualify to take the nursing assistant-certified competency evaluation.

(1) An alternative program shall:

(a) Submit documentation of meeting all requirements of WAC 246-841-420.

(b) Have a competency based curriculum composed of learning objectives and activities. The curriculum content shall include:

(i) Measurement of fluid and food input and output.

(ii) Participation in planning and nursing reporting process.

(iii) Bathing, oral care, and skin care.

(iv) Personal care tasks, appropriate to chronological age and developmental stage of residents.

(v) Grooming and dressing.

(vi) Toileting.

(vii) Eating and hydration, including:

(A) Techniques to prevent choking and aspiration; and

(B) Health and sanitation in food services.

(viii) Basic restorative services.

(A) Use of assistive devices in ambulation, transferring, eating and dressing.

(B) Range of motion.

(C) Turning and positioning.

(D) Transferring and ambulating.

(E) Use and care of prosthetic devices.

(ix) Client resident rights and promotion of independence.

(A) Assistance in getting to and joining in activities appropriate to chronological age of resident.

(B) Respect for client's property.

(C) Use of restraints and acknowledges agency policies that may apply to restraints.

(x) An environment with adequate ventilation, warmth, light, and quiet.

(xi) Rules and regulations, including:

(A) The scope of practice, nursing assistant-certified.

(B) The workers right to know law.

(C) The Uniform Disciplinary Act, including RCW 18.130.180.

(c) Have a program director:

(i) Who is currently licensed as a registered nurse (RN) in good standing in the state of Washington and has a minimum of three years of experience as an RN, with at least one year of experience in direct patient care.

(ii) Who has successfully completed a training course on adult instruction or can demonstrate that he or she has one year experience teaching adults unless the program director works exclusively in a secondary educational setting.

(A) The training course on adult instruction must provide instruction in understanding the adult learner, techniques for teaching adults, classroom methods for teaching adults and audio-visual techniques for teaching adults.

(B) Acceptable experience does not include in-service education or patient teaching.

(iii) Who has a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age if also acting as an instructor.

(2) The program director may select instructional staff to assist in the teaching of the course. Instructional staff must meet the following requirements:

(a) Hold a current Washington state license to practice as a registered or licensed practical nurse in good standing; and
(b) Have a minimum of one year experience within the past three years in caring for the elderly or chronically ill of any age.

(3) Instructional staff may assist the program director in development of curricula, teaching modalities, and evaluation. The instructor must be under the supervision of the program director at all times.

(4) A guest lecturer or individual with expertise in a specific course unit may be used in the classroom setting for teaching without commission approval, following the program director's review of the currency of content. The guest lecturer, where applicable, must hold a license, certificate or registration in good standing in their field of expertise.

NEW SECTION

WAC 246-841-555 Responsibilities of the program director in alternative programs. The program director of an alternative program is responsible for:

(1) Development and use of a curriculum which:

(a) Meets the requirements of WAC 246-841-545; or

(b) Meets the requirements of WAC 246-841-550.

(2) Ensuring compliance with the requirements of WAC 246-841-500 and 246-841-510.

(3) Verifying home care aides-certified have a valid certification before admission to the alternative program.

(4) Verifying medical assistants-certified have certification before admission to the alternative program.

(5) Direct supervision of all students during clinical experience. Direct supervision means an approved program director or instructor observes students performing tasks.

(6) Ensuring the clinical instructor has no concurrent duties during the time he or she is instructing students.

(7) Maintaining an environment acceptable to teaching and learning.

(8) Supervising all instructors involved in the course. This includes clinical instructors and guest lecturers.

(9) Ensuring students are not asked to, or allowed to perform any clinical skill with patients or clients until the students have demonstrated the skill satisfactorily to an instructor in a practice setting.

(10) Evaluating knowledge and skills of students before verifying completion of the course.

(11) Providing students a verification of completion when requirements of the course have been satisfied.

(12) Providing adequate time for students to complete the objectives of the course. The time may vary with skills of the learners and teaching or learning variables.

(13) Establishing an evaluation process to assess mastery of competencies.

NEW SECTION

WAC 246-841-560 Alternative program application for approval, denial, or withdrawal. (1) An applicant for an alternative program must submit a completed application provided by the department of health. The application will include forms and instructions to submit the following:

(a) Program objectives;

(b) Required curriculum and content.

(2) The commission shall comply with WAC 246-841-430 when denying or withdrawing an approval of an alternative program.

(3) An alternative program that has been denied or had an approval withdrawn shall have the right to a hearing to appeal the commission's decision according to the provisions of chapters 18.88A and 34.05 RCW, the Administrative Procedure Act, Parts IV and V.

NEW SECTION

WAC 246-841-570 Recordkeeping and administrative procedures for approved alternative programs. An alternative program shall comply with all the requirements in WAC 246-841-510.

NEW SECTION

WAC 246-841-573 Closure of an alternative program. Before an approved alternative program closes it shall notify the commission in writing, stating the reason and the date of intended closing.

NEW SECTION

WAC 246-841-575 Alternative program—Eligibility to complete the nursing assistant-certified competency examination. Graduates of alternative programs who meet all application requirements are deemed eligible to complete the nursing assistant-certified competency evaluation approved by the commission.

Competency evaluation means the measurement of an individual's knowledge and skills as related to safe, competent performance as a nursing assistant-certified.

NEW SECTION

WAC 246-841-578 Application requirements. To be eligible to apply for nursing assistant-certified from an alternative program the applicant must:

(1) Be currently credentialed as a home care aide-certified; or

(2) Be a medical assistant-certified as defined in WAC 246-841-535;

(3) Have completed a cardiopulmonary resuscitation course;

(4) Have completed seven hours of AIDS education and training as required in chapter 246-12 WAC, part 8; and

(5) Have successfully completed the competency evaluation.

NEW SECTION

WAC 246-841-585 Application for nursing assistant-certified from an alternative program. (1) An applicant for nursing assistant-certified who has successfully completed an approved alternative program as a home care aide-certified must submit to the department:

(a) A completed application for nursing assistant-certified.

(b) A copy of certificate of completion from an approved alternative program for home care aides-certified.

(c) Documentation verifying current certification as a home care aide.

(d) Evidence of completion of a cardiopulmonary resuscitation course.

(e) Evidence of completion of seven hours of AIDS education and training.

(f) Applicable fees as required in WAC 246-841-990.

(2) An applicant for nursing assistant-certified who successfully completed an approved alternative program as a medical assistant-certified must submit to the department:

(a) A completed application for nursing assistant-certified;

(b) A copy of certificate of completion from approved alternative program for medical assistant-certified;

(c) An official transcript from the nationally accredited medical assistant program;

(d) Evidence of completion of an adult cardiopulmonary resuscitation course;

(e) Evidence of completion of seven hours of AIDS education and training; and

(f) Applicable fees as required in WAC 246-841-990.

WSR 11-16-056
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

[Filed July 29, 2011, 8:24 a.m., effective August 29, 2011]

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

Purpose: To bring citizenship/alien status rules into compliance with the federal Center for Medicare and Medicaid (CMS) guidelines. It expands the eligibility group of legally residing individuals which will allow: (1) Some children who are currently in a state-funded medical program to qualify for federally-funded medical coverage, and (2) some pregnant women to have their post partum period covered by federally funded medical. Note: The term PRUCOL has been replaced in this amendment by the term "nonqualified alien." Those formerly known as PRUCOL persons are still eligible for some state-funded benefits.

Citation of Existing Rules Affected by this Order: Amending WAC 388-400-0010, 388-424-0001, 388-424-0006, 388-424-0009, 388-424-0010, 388-424-0015, and 388-450-0156.

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

Adopted under notice filed as WSR 11-10-073 on May 3, 2011.

Changes Other than Editing from Proposed to Adopted Version: **WAC 388-400-0010:**

(2)(b) You are ((~~a alien who is permanently residing in the United States under color of law (PRUCOL) as defined in WAC 388-424-0001~~)) a nonqualified alien as defined in WAC 388-424-0001, who meets the Washington state residency requirements as listed in WAC 388-468-0005;

WAC 388-424-0001:

(1) **"Lawfully present"** are immigrants or noncitizens who have been inspected and admitted into the United States and not overstayed the period for which they were admitted, or have current permission from the U.S. Citizenship and Immigration Services (CIS) to stay or live in the U.S.

(3) **"Nonqualifed [nonqualified] aliens"** are noncitizens who are lawfully present in the U.S. and who are not included in the definition of qualified aliens in subsection (1) of this section. Nonqualifed [nonqualified] aliens ~~may~~ include but are not limited to:

(4) **"Undocumented aliens"** are noncitizens without a lawful immigration status as defined in subsections (2) or (3) of this section….

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

Date Adopted: July 27, 2011.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-17 issue of the Register.

WSR 11-16-073

PERMANENT RULES

EVERETT COMMUNITY COLLEGE

[Filed August 1, 2011, 11:02 a.m., effective September 1, 2011]

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

Purpose: Amend WAC to reflect changes in fitness center location and to update the name of off-campus site, Applied Technology Training Center (ATTC) to Corporate & Continuing Education Center (CCEC).

Reasons Supporting Proposal: Fitness center is no longer on Rockefeller Avenue; Corporate & Continuing Education Center is the official name for the former ATTC by board action.

Citation of Existing Rules Affected by this Order: Amending WAC 132E-133-020.

Statutory Authority for Adoption: Chapter 28B.50 RCW.

Adopted under notice filed as WSR 11-10-067 on May 2, 2011.

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 1, Repealed 0.

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

Date Adopted: July 6, 2011.

Jennifer T. Howard
Vice-President
Administrative Services

AMENDATORY SECTION (Amending WSR 01-02-043, filed 12/28/00, effective 1/28/01)

WAC 132E-133-020 Organization—Operation—Information. (1) Organization. Everett Community College is established in Title 28B RCW as a public institution of higher education. The institution is governed by a five-member board of trustees, appointed by the governor. The board employs a president, who acts as the chief executive officer of the institution. The president establishes the structure of the administration.

(2) Operation. The administrative office is located at the following address:

President's Office
Everett Community College
2000 Tower Street
Everett, WA 98201-1352

The office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, except legal holidays. Educational operations are also located at the following addresses:

Everett Community College
Aviation Maintenance Technician School
9711 - 31st Place W.
Building C-80
Paine Field
Everett, WA 98204

Everett Community College
((~~Applied Technology Training Center~~))
Corporate & Continuing Education Center
2333 Seaway Blvd.
Everett, WA 98204

Everett Community College
School of Cosmetology
9315 G State Avenue
Marysville, WA 98270

Everett Community College
Early Learning Center
820 Waverly Avenue
Everett, WA 98201

Everett Community College
Student Fitness ((~~and Sports~~)) Center
((~~1220 Rockefeller Avenue~~))
2206 Tower Street
Everett, WA 98201

(3) Information. Additional and detailed information concerning the educational offerings may be obtained from the catalog, copies of which are available at the following address:

Everett Community College
2000 Tower Street
Everett, WA 98201-1352

WSR 11-16-103
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-184—Filed August 3, 2011, 10:12 a.m., effective September 3, 2011]

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

Purpose: WAC 220-55-160 Free fishing weekend, language added to clarify that the two-pole endorsement and the Columbia River endorsement are not needed during free fishing weekend. WAC 220-55-220 Two pole endorsement, a portion of Swift Reservoir is removed from the areas where anglers may fish with two poles, due to bull trout holding in this area. WAC 220-55-230 Columbia River endorsement, stream sections are added to the rule for clarification. Gobar Creek, a Kalama River tributary, was added to the list where the endorsement is required. Cougar Lake was removed, and the description for Swift Reservoir was revised. WAC 220-56-240 Daily limits forage fish and other food fish not otherwise provided for, clarifies the daily limit of fifteen for shiner perch. During the last rule change cycle, shiner perch were inadvertently included in the species that have a two-fish daily limit. WAC 220-56-270 Smelt—Areas and seasons, closes fishing for eulachon smelt state-wide, due to their "threatened" listing under the Endangered Species Act. Adds the scientific name for the smelt species to clarify that the closure applies only to this species.

Reasons Supporting Proposal: All of these rule changes were adopted by the Washington fish and wildlife commission on February 5, 2011, to provide for maximum recreational fishing opportunity while conserving fish resources. By the time the Washington department of fish and wildlife (WDFW) filed the rule-making order (CR-103P) on April 12, 2011, to make these rules effective thirty-one days later, the time limit for filing all of the adopted rules except WAC 232-28-619 had expired. This rule-making order adopts as permanent rules the previously expired sections.

Citation of Existing Rules Affected by this Order: Amending WAC 220-55-160, 220-55-220, 220-55-230, 220-55-240, and 220-56-270.

Statutory Authority for Adoption: RCW 77.04.020 and 77.12.047.

Adopted under notice filed as WSR 11-09-060 on April 18, 2011.

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 5, 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: August 3, 2011.

Philip Anderson
Director

AMENDATORY SECTION (Amending Order 06-135, filed 6/13/06, effective 7/14/06)

WAC 220-55-160 Free fishing weekend. The Saturday and Sunday following the first Monday in June is declared to be free fishing weekend in Washington. On this weekend a fishing license is not required for any person, regardless of age or residency, to fish for or possess fish and shellfish and a fish and wildlife lands vehicle use permit is not required to utilize department parking facilities except that it is unlawful to fish for or possess any species for which a catch record is required without a valid catch record card in possession. Anglers may fish with two poles in all lakes where it is legal to do so without purchasing a two-pole endorsement, and may also fish in all open areas of the Columbia River and tributaries without purchasing a Columbia River endorsement. During free fishing weekend only the license, endorsements, and permit provided for in this section are affected, and all other rules including the catch record card requirement remain in effect.

AMENDATORY SECTION (Amending Order 10-64, filed 3/19/10, effective 5/1/10)

WAC 220-55-220 Two pole endorsement. Anglers who are in possession of a valid two pole endorsement may fish with two lines in all lakes and ponds open to fishing, with the following exceptions:

Water Body	County	
Para-juvenile Lake	Adams	
Quail Lake	Adams	
Headgate Pond	Asotin	
Columbia Park Pond	Benton	
Blackbird Island Pond	Chelan	
Lake Wenatchee	Chelan	
Aldwell Lake	Clallam	
Beaver Lake	Clallam	
Carrie Blake Pond	Clallam	
Dickey Lake	Clallam	
Lake Pleasant	Clallam	
Lincoln Pond	Clallam	
Sutherland Lake	Clallam	
Vancouver Lake	Clark	Includes all other waters west of Burlington-Northern Railroad from Columbia River drawbridge near Vancouver downstream to Lewis River
Big Four Lake	Columbia	
Dayton Pond	Columbia	
Blue Lake	Cowlitz	
Castle Lake	Cowlitz	
Coldwater Lake	Cowlitz	
Lewis River Power Canal	Cowlitz	Includes old Lewis River streambed between Swift No.1 powerhouse and Swift No. 2 powerhouse

Water Body	County	
Merrill Lake	Cowlitz	
Silver Lake	Cowlitz	
Grimes Lake	Douglas	
Pit Lake	Douglas	
Long Lake	Ferry	
Beda Lake	Grant	
Brookies Lakes	Grant	
Dry Falls Lake	Grant	
Dusty Lake	Grant	
Homestead Lake	Grant	
Lenice Lake	Grant	
Lenore Lake	Grant	
Merry Lake	Grant	
Nunnally Lake	Grant	
Ping Pond	Grant	
Damon Lake	Grays Harbor	
Mill Creek Pond	Grays Harbor	
Promised Land Pond	Grays Harbor	
Quigg Lake	Grays Harbor	Located at Friends Landing near Montesano
Shye Lake	Grays Harbor	
Vance Creek Pond #1	Grays Harbor	
Vance Creek Pond #2	Grays Harbor	
Wynoochee Reservoir	Grays Harbor	
Anderson Lake	Jefferson	
Gibbs Lake	Jefferson	
Horseshoe Lake	Jefferson	
Teal Lake	Jefferson	
Lake Sammamish	King	
Lake Union	King	
Lake Washington	King	Including that portion of Sammamish River from 68th Ave. NE bridge downstream
Lake Washington Ship Canal	King	(Including Lake Union, Portage Bay, and Salmon Bay) waters east of a north-south line 400' west of the Chittenden Locks to the MontLake Bridge
Mill Pond	King	Auburn
Old Fishing Hole Pond	King	Kent
Portage Bay	King	
Rattlesnake Lake	King	
Ravensdale Lake	King	
Salmon Bay	King	
Swans Mill Pond	King	
Koeneman Lake	Kitsap	Formerly Fern Lake
Easton Lake	Kittitas	
Kachess Lake	Kittitas	
Keechelus Lake	Kittitas	
Kiwanis Pond	Kittitas	
Naneum Pond	Kittitas	
Cowlitz Falls Reservoir	Lewis	
Fort Borst Park Pond	Lewis	
Mayfield Lake	Lewis	Mayfield Dam to Mossyrock Dam
Packwood Lake	Lewis	
Scanewa Lake	Lewis	Cowlitz Falls Reservoir
Walupt Lake	Lewis	
Willame Lake	Lewis	
Coffeepot Lake	Lincoln	
Cady Lake	Mason	
Cushman Reservoir	Mason	
Prices Lake	Mason	
Stump Lake	Mason	
Aeneas Lake	Okanogan	
Big Twin Lake	Okanogan	
Black Lake	Okanogan	
Blue Lake	Okanogan	Near Wannacut Lake
Blue Lake	Okanogan	Sinlahekin Creek
Campbell Lake	Okanogan	
Chopaka Lake	Okanogan	
Cougar Lake	Okanogan	Lost River
Davis Lake	Okanogan	
Ell Lake	Okanogan	
Green Lake	Okanogan	
Green Lake	Okanogan	Lower Green Lake
Hidden Lake	Okanogan	Lost River
Rat Lake	Okanogan	
Silvernail Lake	Okanogan	
Cases Pond	Pacific	
Middle Nemah Pond	Pacific	
Mooses Pond	Pacific	
Owens Pond	Pacific	
South Bend Mill Pond	Pacific	
Browns Lake	Pend Oreille	
Muskegon Lake	Pend Oreille	
Bradley Lake	Pierce	
De Coursey Pond	Pierce	
Ohop Lake	Pierce	
Tanwax Lake	Pierce	
Wapato Lake	Pierce	
Granite Lakes	Skagit	Near Marblemount
Northern State Hospital Pond	Skagit	
Pass Lake	Skagit	
Vogler Lake	Skagit	
Drano Lake	Skamania	(Little White Salmon River) downstream of markers on point of land downstream and across from Little White Salmon National Fish Hatchery and upstream of Hwy. 14 bridge
Swift Reservoir	Skamania	From ((~~dam to~~)) markers approximately ((~~1~~)) 3/8 mile below Eagle Cliff Bridge to bridge
Ebey Lake	Snohomish	Little Lake
Fortson Mill Pond #2	Snohomish	
Jennings Park Pond	Snohomish	
Monte Cristo Lake	Snohomish	
North Gissburg Pond	Snohomish	
Spada Lake	Snohomish	
Amber Lake	Spokane	

Water Body	County	
Bear Lake	Spokane	
Medical Lake	Spokane	
North Silver Lake	Spokane	
Bayley Lake	Stevens	
Lucky Duck Pond	Stevens	
Mcdowell Lake	Stevens	
Rigley Lake	Stevens	
Kennedy Creek Pond	Thurston	
Long's Pond	Thurston	
Mclane Creek Ponds	Thurston	
Munn Lake	Thurston	
Jefferson Park Pond	Walla Walla	
Lions Park Pond	Walla Walla	College Place
Diablo Lake	Whatcom	
Gorge Lake	Whatcom	
Lake Whatcom	Whatcom	
Ross Lake	Whatcom	
Squalicum Lake	Whatcom	
Garfield Juvenile Pond	Whitman	
Bumping Lake	Yakima	
Clear Lake	Yakima	
Leech Lake	Yakima	White Pass area
Mud Lake	Yakima	
Myron Lake	Yakima	
Rimrock Lake	Yakima	
Sarge Hubbard Park Pond	Yakima	
Yakima Sportsmen's Park Ponds	Yakima	

Note: The two pole endorsement is not valid in the Columbia and Snake rivers except as noted in Lake Roosevelt and Rufus Woods Lake.

AMENDATORY SECTION (Amending Order 10-64, filed 3/19/10, effective 5/1/10)

WAC 220-55-230 Columbia River endorsement. Anglers fifteen years of age or older must be in possession of a valid Columbia River endorsement to fish for salmon or steelhead in the following waters:

Mainstem Columbia River from the Rocky Point/Tongue Point line to Chief Joseph Dam
Deep River (Wahkiakum County)
Grays River (Wahkiakum County) mouth to mouth of South Fork
Grays River, West Fork mouth to hatchery intake footbridge
Grays River, East Fork
Skamokawa River (Wahkiakum County) mouth (Hwy 4 Bridge) to forks below Oatfield and Middle Valley Road
Elochoman River (Wahkiakum County) mouth to mouth of West Fork
Mill Creek (Lewis County)
Abernathy Creek (Cowlitz County) mouth to Abernathy Falls
Germany Creek (Cowlitz County) mouth to end of Germany Creek Road
Coal Creek (Cowlitz County) mouth to 400 feet below falls
Cowlitz River (Cowlitz County) mouth to mouth of Ohanapecosh and Muddy forks
Blue Creek mouth to Spencer Road
Lacamas Creek
Mill Creek mouth to hatchery road crossing culvert
Olequa Creek
Tilton River mouth to West Fork
Tilton River, East Fork
Tilton River, North Fork
Tilton River, South Fork
Tilton River, West Fork
Mayfield Lake
((~~Riffe Lake~~))
Lake Scanewa
Cispus River (Lewis County) mouth to North Fork
Coweeman River (Cowlitz County)
Toutle River (Cowlitz County) mouth to forks
Toutle River, North Fork
Toutle River, South Fork
Green River (Cowlitz County) mouth to Miner's Creek
((~~Green River (Cowlitz County)~~))
Kalama River (Cowlitz County) mouth to Kalama Falls
Gobar Creek (Cowlitz County)
Lewis River (Clark/Cowlitz counties) mouth to mouth of East Fork
Lewis River, North Fork mouth to Merwin Dam
Lewis River, East Fork
Cedar Creek (Clark County)
Salmon Creek (Clark County) mouth to 72nd Ave. N.E.
Washougal River (Clark County)
Washougal River West, North Fork
Little Washougal
Camas Slough (Clark County) (waters outside the mouth of the Washougal River, north of Lady Island, and downstream of the Highway 14 Bridge at the upstream end of Lady Island)
Drano Lake (Skamania County) (little White Salmon River downstream of the markers on point of land downstream and across from Little White Salmon National Fish Hatchery and upstream of Highway 14 Bridge)
Hamilton Creek (Skamania County)
Rock Creek (Skamania County)
Wind River (Skamania County)
White Salmon River (Klickitat/Skamania counties) mouth to Northwestern (Condit) Dam
Klickitat River (Klickitat County)
Walla Walla River (Walla Walla County) and tributaries
Mill Creek (Walla Walla County)
Touchet River (Columbia/Walla Walla counties) mouth to confluence of North Fork and South Fork
Touchet River, North Fork
Touchet River, South Fork
Touchet River, Wolf Fork
Grande Ronde River (Asotin County)
Snake River mainstem
Palouse River (Whitman County) (below the falls)
Tucannon River (Columbia/Garfield counties)
Yakima River (Benton/Yakima/Kittitas counties) mouth to 400 feet below Prosser Dam and Sunnyside (Parker) Dam to Roza Dam

Wenatchee River mouth to Lake Wenatchee (including Lake Jolanda)

Chelan River (Chelan County) mouth (railroad bridge) to Chelan PUD safety barrier below the powerhouse

Icicle River (Chelan County) mouth to Leland Creek

Lake Wenatchee (Chelan County)

Entiat River (Chelan County) mouth to Entiat Falls

Methow River (Okanogan County) mouth to Foghorn Dam

Okanogan River (Okanogan County)

Lake Osoyoos (Okanogan County)

Similkameen River (Okanogan County) mouth to Enloe Dam

AMENDATORY SECTION (Amending Order 10-64, filed 3/19/10, effective 5/1/10)

WAC 220-56-240 Daily limits forage fish and other food fish not otherwise provided for. It is unlawful for any person to retain more than the following quantities and sizes of food fish taken for personal use. Unless otherwise provided, other food fish fishing is open the entire year:

(1) Forage fish: 10 pounds in the aggregate. The possession limit is two daily limits in fresh form. Additional forage fish may be possessed in frozen or processed form.

(2) Shiner perch: Daily limit 15 fish.

(3) All other marine food fish not otherwise provided for in this chapter except albacore, yellowfin, skipjack, and northern bluefin tuna and all mackerel: Daily limit two fish.

AMENDATORY SECTION (Amending Order 06-67, filed 4/11/06, effective 5/12/06)

WAC 220-56-270 Smelt—Areas and seasons. (1) ((~~Smelt~~)) Unlawful to fish for or possess Columbia River smelt or eulachon (*Thaleichthys pacificus*).

(2) Fishing for smelt other than Columbia River smelt or eulachon (*Thaleichthys pacificus*) is permitted the entire year on Pacific Ocean beaches and in all rivers concurrent with a salmon or gamefish opening, except closed in the Columbia River and tributaries.

((~~(2) Smelt~~)) (3) Fishing for smelt other than Columbia River smelt or eulachon (*Thaleichthys pacificus*) is open in Puget Sound and the Strait of Juan de Fuca the entire year except closed weekly from 8:00 a.m. Wednesday to 8:00 a.m. Friday for all types of gear except forage fish jigger gear and closed year-round in Catch Record Card Area 12. Violation of this subsection is an infraction, punishable under RCW 77.15.160.

((~~(3)~~)) (4) It is unlawful to possess smelt taken with gear in violation of the provisions of this section. Possession of smelt while using gear in violation of the provisions of this section is a rebuttable presumption that the smelt were taken with such gear. Possession of such smelt is punishable under RCW 77.15.380 Unlawful recreational fishing in the second degree—Penalty, unless the smelt are taken in the amounts or manner to constitute a violation of RCW 77.15.370 Unlawful recreational fishing in the first degree—Penalty.

WSR 11-16-106
PERMANENT RULES
DEPARTMENT OF REVENUE

[Filed August 3, 2011, 11:02 a.m., effective September 3, 2011]

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

Purpose: The department has amended these rules to recognize provisions of 2ESSB 6143, Part II ***Tax Avoidance Transactions***, sections 207-213. The rule amendments include the following legislative changes and clarifications:

- The date on which an option agreement is executed is the date on which the transfer or acquisition of a controlling interest pursuant to the option is deemed to occur, for the purpose of determining whether a controlling interest was transferred or acquired within a twelve-month period;
- The department may collect REET on the transfer or acquisition of a controlling interest in a corporation from either the corporation or the buyer, or, if the corporation is not publicly traded, from the seller;
- A parent corporation of a wholly-owned subsidiary is responsible for REET if the subsidiary transfers real property to a third party and then dissolves before payment of the tax;
- Providing notice to the department within thirty days of a sale no longer exempts a buyer from liability for REET that has not been paid by the seller; and
- A lien for any unpaid REET attaches to each parcel of property in this state owned by an entity in which a controlling interest has been transferred.

WAC 458-61A-102 has also been amended to direct readers to chapter 26.60 RCW for the definition of "domestic partner" to recognize the change made by HB 1649 (chapter 9, Laws of 2011).

Citation of Existing Rules Affected by this Order: Amending WAC 458-61A-100 Real estate excise tax—Overview, 458-61A-101 Taxability of the transfer or acquisition of the controlling interest of an entity with an interest in real property located in this state, 458-61A-102 Definitions, 458-61A-107 Option to purchase, and 458-61A-301 Payment of tax, collection responsibility, audit responsibility, and tax rulings.

Statutory Authority for Adoption: RCW 82.45.150, 82.32.300, and 82.01.060.

Adopted under notice filed as WSR 11-07-068 on March 21, 2011.

Changes Other than Editing from Proposed to Adopted Version: The definition of "domestic partner" has been changed to recognize the change made by HB 1649 (chapter 9, Laws of 2011).

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 5, 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: August 3, 2011.

Alan R. Lynn
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-23-093, filed 11/16/05, effective 12/17/05)

WAC 458-61A-100 Real estate excise tax—Overview. (1) **Introduction.** Chapter 82.45 RCW imposes an excise tax on every sale of real estate in the state of Washington. All sales of real property in this state are subject to the real estate excise tax unless specifically exempted by chapter 82.45 RCW and these rules. The general provisions for the administration of the state's excise taxes contained in chapter 82.32 RCW apply to the real estate excise tax, except as provided in RCW 82.45.150. This chapter provides applicable definitions, describes procedures for payment, collection, and reporting of the tax, explains when penalties and interest are imposed on late payment, describes those transactions exempted from imposition of the tax, and explains the procedures for refunds and appeals.

Legislation adopted in 2010. Effective May 1, 2010, chapter 23, Laws of 2010 sp. sess. established new requirements regarding:

(a) Sales of real estate that result from the transfer of a controlling interest in an entity that owns real property. See WAC 458-61A-101.

(b) Enforcement of tax liability. See WAC 458-61A-301.

(2) **Imposition of tax.**

(a) The taxes imposed are due at the time the sale occurs, are the obligation of the seller, and, in most instances, are collected by the county upon presentation of the documents of sale for recording in the public records.

(b) If there is a sale of the controlling interest in an entity that owns real property in this state, the tax is paid to the department at the time the interest is transferred. See WAC 458-61A-101.

(3) **Rate of tax.** The rate of the tax is set forth in RCW 82.45.060. Counties, cities, and towns may impose additional taxes on sales of real property on the same incidences, collection, and reporting methods authorized under chapter 82.45 RCW. See chapter 82.46 RCW.

(4) **Nonprofit organizations.** Transfers to or from an organization exempt from ad valorem property taxes under chapter 84.36 RCW, or from federal income tax, because of the organization's nonprofit or charitable status are nevertheless subject to the real estate excise tax unless specifically exempt under chapter 82.45 RCW or these rules.

(5) **Sales in Indian country.** A sale of real property located in Indian country by an enrolled tribe or tribal member is not subject to real estate excise tax. See WAC 458-20-192 for complete information regarding the taxability of transactions involving Indians and Indian country.

AMENDATORY SECTION (Amending WSR 05-23-093, filed 11/16/05, effective 12/17/05)

WAC 458-61A-101 Taxability of the transfer or acquisition of the controlling interest of an entity with an interest in real property located in this state. (1) **Introduction.** The transfer of a controlling interest in an entity that has an interest in real property in this state is considered a taxable sale of the entity's real property for purposes of the real estate excise tax under chapter 82.45 RCW. This rule explains the application of the tax on those transfers.

Legislation adopted in 2010. Effective May 1, 2010, chapter 23, Laws of 2010 1st sp. sess. established new requirements regarding option agreements and regarding enforcement of tax liability. See subsections (3) and (6) through (8) of this section.

(2) **Definitions.** For the purposes of this chapter, the following definitions apply unless the context requires otherwise.

(a) **"Controlling interest"** means:

(i) In the case of a corporation, either fifty percent or more of the total combined voting power of all classes of stock of the corporation entitled to vote, or fifty percent of the capital, profits, or beneficial interest in the voting stock of the corporation; and

(ii) In the case of a partnership, association, trust, or other entity, fifty percent or more of the capital, profits, or beneficial interest in such partnership, association, trust, or other entity.

Examples. The following examples, while not exhaustive, illustrate some of the circumstances in which the transfer of an interest in an entity may or may not be taxable. These examples should be used only as a general guide. The status of each situation must be determined after a review of all of the facts and circumstances.

(A) Able and Baker each own 40% of the voting shares of a corporation, Flyaway, Inc. Charlie, Delta, Echo, and Frank each own 5% voting shares. Charlie acquires Baker's 40% interest, and Delta's and Echo's 5% interests. This is a taxable acquisition because a controlling interest (50% or more) was acquired by Charlie (40% from Baker plus 5% from Delta and 5% from Echo). However, if Charlie, Delta, and Echo were to transfer their shares (totaling 15%) to Able, those transfers would not be taxable. Although Able would own 55% of the corporation, only a 15% interest was transferred and acquired, so the acquisition by Able is not taxable.

(B) Melody LLC consists of a general partner and three limited partners, each possessing a 25% interest. Even though the general partner controls the management and daily operations, a 25% interest is not a controlling interest. If someone were to acquire a 50% or greater interest from any of the existing partners, there would be a taxable acquisition of a controlling interest. If one partner acquires an additional 25% interest from another partner for a total of a 50% interest, no transfer or acquisition of a controlling interest occurs because less than 50% is transferred and acquired.

(C) Anne, Bobby, Chelsea, and David each own 25% of the voting shares of a corporation. The corporation redeems the shares of Bobby, Chelsea, and David. Anne now owns all the outstanding shares of the corporation. A taxable transfer occurred when the corporation redeemed the shares of Bobby, Chelsea, and David.

(D) Andrew owns 75% of the voting shares of a corporation. Andrew transfers all of his stock by 25% portions of the shares in three separate and unrelated transactions to Betsy, Carolyn, and Daniel, who are not acting in concert. A taxable transfer of a controlling interest occurs when Andrew transfers 75% of the voting shares of the corporation, even though no one has subsequently acquired a controlling interest.

(E) Big Corporation has two stockholders, Adrian and Britain. Adrian owns 90 shares of stock (90%) and Britain owns 10 shares of stock (10%). Big Corporation owns 60% of the stock of Little Corporation, which owns real property. Adrian, by virtue of owning 90% of Big Corporation's stock, has a 54% interest in Little Corporation (90% interest in Big multiplied by the 60% interest Big has in Little equals the 54% interest Adrian has in Little). Adrian sells his 90 shares of stock in Big to Britain. Adrian, by selling his 90 shares of Big stock, has transferred a controlling interest (54%) in an entity that owns real property (Little). This transfer is subject to the real estate excise tax.

(F) Assume the same facts as in Example (E) of this subsection, except that Big owns only 50% of Little's stock. Since Adrian has not transferred and Britain has not acquired a controlling interest in Little (90% x 50% = 45%), the real estate excise tax does not apply. If, however, Big had transferred its 50% interest in Little, that would be a transfer of a controlling interest and it would be subject to the real estate excise tax.

(b) The terms **"person"** or **"company"** mean any individual, receiver, administrator, executor, assignee, trustee in bankruptcy, trust, estate, firm, copartnership, joint venture, club, company, joint stock company, business trust, municipal corporation, the state of Washington or any political subdivision thereof, corporation, limited liability company association, society, or any group of individuals acting as a unit, whether mutual, cooperative, fraternal, nonprofit, or otherwise, and the United States or any agency or instrumentality thereof.

(c) **"True and fair value"** means market value, which is the amount of money that a willing, but unobliged, buyer would pay a willing, but unobligated, owner for real property, taking into consideration all reasonable, possible uses of the property.

(d) **"Twelve-month period"** is any period of twelve consecutive months and may span two calendar years.

(e) **"Acting in concert"** occurs:

(i) When one or more persons have a relationship with each other such that one person influences or controls the actions of another through common ownership. For example, if a parent corporation and a wholly owned subsidiary each purchase a 25% interest in an entity, the two corporations have acted in concert and acquired a controlling (i.e., at least 50%) interest in the entity.

(ii) Where buyers are not commonly controlled or owned, but the unity of purpose with which they have negotiated and will complete the acquisition of ownership interests, indicates that they are acting together. For example, three separate individuals who decide together to acquire control of a company jointly through separate purchases of 20% interests in the company act in concert when they acquire the interests.

(3) **In general.** In order for the tax to apply when the controlling interest in an entity that owns real property is transferred, the following must have occurred:

(a) The transfer or acquisition of the controlling interest occurred within a twelve-month period((~~;~~)).

Effective May 1, 2010, solely for the purpose of determining whether a transfer or acquisition pursuant to the exercise of an option occurred within a twelve-month period, the date on which the option agreement was executed is deemed to be the date of the transfer or acquisition;

(b) The controlling interest was transferred in a single transaction or series of transactions by a single person or acquired by a single person or a group of persons acting in concert;

(c) The entity has an interest in real property located in this state;

(d) The transfer is not otherwise exempt under chapters 82.45 RCW and 458-61A WAC; and

(e) The transfer was made for valuable consideration.

(4) **Measure of the tax.** The measure of the tax is the "selling price." For the purpose of this rule, "selling price" means the true and fair value of the real property owned by the entity at the time the controlling interest is transferred.

(a) If the true and fair value of the property cannot reasonably be determined, one of the following methods may be used to determine the true and fair value:

(i) A fair market value appraisal of the property; or

(ii) An allocation of assets by the seller and the buyer made pursuant to section 1060 of the Internal Revenue Code of 1986, as amended or renumbered as of January 1, 2005.

(b) If the true and fair value of the property to be valued at the time of the sale cannot reasonably be determined by either of the methods in (a) of this subsection, the market value assessment for the property maintained on the county property tax rolls at the time of the sale will be used as the selling price.

(c) **Examples.**

(i) A partnership owns real property and consists of two partners, Amy and Beth. Each has a 50% partnership interest. The true and fair value of the real property owned by the partnership is $100,000. Amy transfers her 50% interest in the partnership to Beth for valuable consideration. The taxable selling price is the true and fair value of the real property owned by the partnership, or $100,000.

(ii) A corporation consists of two shareholders, Chris and Dilbert. The assets of the corporation include real property, tangible personal property, and other intangible assets (goodwill, cash, licenses, etc.). An appraisal of the corporation's assets determines that the values of the assets are as follows: $250,000 for real property; $130,000 for tangible personal property; and $55,000 for miscellaneous intangible assets. Chris transfers his 50% interest to Ellie for valuable consideration. The taxable selling price is the true and fair

value of the real property owned by the corporation, or $250,000.

(iii) An LLC owns real property and consists of two members, Frances and George. Each has a 50% LLC interest. Frances transfers her 50% interest to George. In exchange for the transfer, George pays Frances $100,000. The true and fair value of the real property owned by the LLC is unknown. There is no debt on the real property. A fair market value appraisal is not available. The market value assessment for the property maintained on the county property tax rolls is $275,000. The taxable selling price is the market value assessment, or $275,000.

(5) **Persons acting in concert.** The tax applies to acquisitions made by persons acting in concert, as defined in subsection (2)(f) of this section.

(a) Where persons are not commonly controlled or influenced, factors that indicate whether persons are acting in concert include:

(i) A close relation in time of the transfers or acquisitions;

(ii) A small number of purchasers;

(iii) Mutual terms contained in the contracts of sale; and

(iv) Additional agreements to the sales contract that bind the purchasers to a course of action with respect to the transfer or acquisition.

(b) If the acquisitions are completely independent, with each purchaser buying without regard to the identity of the other purchasers, then the persons are not acting in concert, and the acquisitions will be considered separate acquisitions.

(c) **Example.** Able owns 100% of Emerald Corporation, which owns real property. As a group, Baker, Charlie, Delta, and Echo negotiate to acquire all of Able's interest in Emerald. Baker, Charlie, Delta, and Echo each acquire 25% of Able's interest. The contracts of Baker, Charlie, Delta, and Echo are identical and the purchases occur simultaneously. Baker, Charlie, Delta, and Echo also negotiated an agreement binding themselves to a course of action with respect to the acquisition of Emerald and the terms of the shareholders agreement that will govern their relationship as owners of Emerald. Baker, Charlie, Delta, and Echo are acting in concert and their acquisitions from Able are treated as a single acquisition of a controlling interest that is subject to the real estate excise tax.

(6) **Date of sale.**

(a) When the controlling interest is acquired in one transaction, the actual date control is transferred is the date of sale. Examples of when an interest in an entity is transferred include when payment is received by the seller and the shares of stock are delivered to the buyer, or when payment is received by the seller and partnership documents are signed, etc.

((~~However, if~~)) (b) When the parties enter into an agreement to acquire or transfer a controlling interest over time through a series of transactions, the date of sale is deemed the date of the agreement arranging the transactions. The agreement results in the transfer of both a present interest and a beneficial interest in the entity, the sum of which results in a controlling interest, regardless of whether the first of the successive transactions is more than twelve months prior to the final transaction.

((~~(b)~~)) (c) When the controlling interest is transferred or acquired pursuant to the exercise of an option, the date upon which the option is exercised is the date of sale.

(d) **Examples.**

(i) Andrew owns 100% of the voting shares of Topaz Corporation. Andrew signs a binding agreement to transfer 51% of his shares in the corporation to Ted. The agreement states that the transfer will occur as follows: 49% of the shares will be transferred on January 1st, and the remaining 2% of the shares will be transferred on February 1st of the following year. Andrew has contractually agreed to sell 51% of the voting shares in Topaz within a twelve-month period, even though the shares will not actually be transferred to Ted until later. The date of sale is the date of the agreement, and REET is due upon the true and fair value of the property as of the date of the agreement.

(ii) Matt acquires a 10% interest in an entity which owns an apartment building under construction worth $500,000 from Simon on January 30th. On July 30th Matt acquires a 30% interest in the same entity from Mary, but the building is now worth $900,000. On September 30th Matt acquires a 10% interest in the same entity from Ruth, but the building is now worth $1,000,000. These are three separate and completely independent transfers. The final transfer allowed Matt to acquire, within twelve months, a controlling interest in an entity that owns real property. September 30th is the date of sale.

To determine the sellers' proportional tax liability in the example above, the series of transactions is viewed as a whole. Note both the individual and the total interests transferred. Here, Simon and Mary each conveyed 10% interests, while Ruth conveyed a 30% interest, with a total of a 50% interest being conveyed. To determine the liability percentage for each seller, divide the interest each conveyed by the total interest conveyed (Here, Simon and Mary: 10/50 = 20%; Ruth: 30/50 = 60%). This results in tax liability percentages here for Simon and Mary of 20% each and for Ruth, 60%.

To determine the amount of tax owed, the percentage is applied to the value of the property at the time of conveyance. In the example above, the value of the property to which the percentage applies is dependent on the time of each transfer (i.e., Simon's 20% on the $500,000; Mary's 60% on the $900,000; Ruth's 20% on the $1,000,000).

(7) **Tax liability.** When there is a transfer or acquisition of a controlling interest in an entity that has an interest in real property, the seller of the interest is generally liable for the tax.

(a) Prior to May 1, 2010, when the seller ((~~has~~)) had not paid the tax by the due date and neither the buyer nor the seller ((~~has~~)) notified the department of the sale within thirty days of the sale, the buyer ((~~is~~)) was also liable for the tax. ((~~(b)~~)) When the buyer ((~~has~~)) notified the department of the sale within thirty days of the sale, the buyer ((~~will not be~~)) was not held personally liable for any tax due. Effective May 1, 2010, however, notice to the department by either the seller or the buyer does not exempt the buyer from liability for the tax, if the department cannot collect the tax from the seller.

(b) Effective May 1, 2010, the department may, at the department's option, enforce the obligation of the seller.

(i) If the entity is a corporation;

(A) Against the corporation;

(B) Against the person or persons who acquired the controlling interest; or

(C) When the corporation is not a publicly traded company, against the person or persons who transferred the controlling interest.

(ii) If the entity is a partnership, association, trust, or other entity that is not a corporation;

(A) Against the entity; or

(B) Against the person or persons who transferred or acquired the controlling interest.

(c) Unpaid tax is a specific lien on each parcel of real property in this state owned by an entity in which a controlling interest has been transferred or acquired. The lien attaches from the time of sale until the tax is paid, which lien may be enforced in the manner prescribed for the foreclosure of mortgages.

(8) **Reporting requirements.**

(a) The transfer of a controlling interest in real property must be reported to the department when no instrument is recorded in the official real property records of the county in which the property is located. If the transfer is not taxable due to an exemption, that exemption should be stated on the affidavit.

(((~~(a)~~))) (i) The sale must be reported by the seller to the department within five days from the date of the sale on the department of revenue affidavit form, DOR Form 84-0001B. The affidavit form must be signed by both the seller and the buyer, or their agent, and must be accompanied by payment of the tax due.

(((~~(b)~~))) (ii) The affidavit form may also be used to disclose the sale, in which case:

(((~~(i)~~))) (A) It must be signed by the person making the disclosure; and

(((~~(ii)~~))) (B) It must be accompanied by payment of the tax due only when submitted by a seller reporting a taxable sale.

(((~~(c)~~))) (iii) Any person who intentionally makes a false statement on any return or form required to be filed with the department under this chapter is subject to penalty of perjury.

(((~~(d)~~))) (iv) **Examples.** The following examples, while not exhaustive, illustrate some of the circumstances in which the transfer of an interest in an entity must be reported to the department. These examples should be used only as a general guide. The status of each situation must be determined after a review of all of the facts and circumstances.

(((~~(i)~~))) (A) Simon and Peter each own 40% of the voting shares of a corporation. Paul, Matthew, Mark, and John each own 5% voting shares. Paul acquires Peter's 40% interest, and Matthew's and Mark's 5% interests. This is a taxable acquisition because a controlling interest (50% or more) was acquired by Paul (40% from Peter plus 5% from Matthew and 5% from Mark). This transaction must be reported.

(((~~(ii)~~))) (B) Assume same facts as in example (((~~(d)(i)~~))) (iv)(A) of this subsection. ((~~Paul's attorney advises him that for his protection, Paul should file an affidavit to disclose the sale.~~)) Paul files an affidavit to disclose the sale to the department within thirty days of the date of sale. Peter, Matthew, and Mark go on vacation and the affidavit and required tax payment is not sent to the department. The department notifies Peter, Matthew, and Mark of their tax liability, which now includes interest and penalties. ((~~Due to Paul's disclosure,~~)) Effective May 1, 2010, Paul is not relieved of ((~~any~~)) personal liability for the tax, interest, or penalties, if the department cannot collect from Peter, Matthew, and Mark.

(((~~(iii)~~))) (C) Assume the same facts as in example (((~~(d)(i)~~))) (iv)(A) of this subsection, except Paul only acquires Peter's 40% interest and Matthew's 5% interest. This is not a taxable acquisition because a controlling interest (50% or more) was not acquired by Paul. This transaction does not need to be reported.

(b) Under RCW 43.07.390, an entity must report the transfer of a controlling interest to the secretary of state, and, effective May 1, 2010, also the granting of any option that, if exercised, would result in a transfer or acquisition of a controlling interest. Failure to report a taxable transfer subjects the entity to interest and penalties.

(9) **Due date, interest and penalties.** The tax imposed is due and payable immediately on the date of sale. See WAC 458-61A-306 for interest and penalties that may apply.

(10) **Transfers after tax has been paid.** When there is a transfer or acquisition of a controlling interest in an entity and the real estate excise tax is paid on the transfer, and there is a subsequent acquisition of an additional interest in the same entity within the same twelve-month period by a person acting in concert with the previous buyer(s), the subsequent seller is liable for its proportional portion of the tax. After payment by the subsequent seller of its proportional share, the person(s) who previously paid the tax may apply to the department for a refund of the amount overpaid because of the new proportional amount paid as a result of the subsequent transfer or acquisition.

(11) **Exemptions.** Because transfer and acquisition of a controlling interest in an entity that owns real estate in this state is statutorily defined as a "sale" of the real property owned by the entity, the exemptions of chapter 82.45 RCW and this chapter also apply to the sale of a controlling interest.

Examples.

(a) The merger of a wholly owned subsidiary owning real property located in this state with another subsidiary wholly owned by the same parent is a transfer of a controlling interest. However, this transfer may be exempt from taxation on two grounds. First, it may be exempt because it is a mere change in form or identity (see WAC 458-61A-211). Second, it may be exempt if it qualifies under the nonrecognition of gain or loss provisions of the Internal Revenue Code for entity formation, liquidation and dissolution, and reorganization. (See WAC 458-61A-212.)

(b) Taki owns 100% of a corporation. Taki wants her child, Mieko, and corporate manager, Sage, to be co-owners with her in the corporation. Taki makes a gift of 50% of the voting stock to Mieko and sells 33 1/3% to Sage. Although a controlling interest in the corporation has been transferred to and acquired by Mieko, it is not taxed because a gift is an exempt transfer and not considered for purposes of determining whether a controlling interest has transferred. The sale of the 33 1/3% interest to Sage is not a controlling interest, and is not taxed.

(c) Richard owns 75% of the voting stock of a corporation that owns real estate located in this state. Richard

pledges all of his corporate stock to secure a loan with a bank. When Richard defaults on the loan and the bank forecloses on Richard's stock in the corporation, the transfer and acquisition of the controlling interest of the entity is not a taxable transaction because foreclosures of mortgages and other security devices are exempt transfers. (See WAC 458-61A-208.)

AMENDATORY SECTION (Amending WSR 08-24-095, filed 12/2/08, effective 1/2/09)

WAC 458-61A-102 Definitions. For the purposes of chapter 458-61A WAC, the following definitions apply unless the context requires otherwise:

(1) **"Affidavit"** means the real estate excise tax affidavit provided by the department for use by taxpayers in reporting transfers of real property. Both the seller/grantor and the buyer/grantee, or their agents, sign the affidavit under penalty of perjury. The term also includes the form used to report to the department transfers and acquisitions of a controlling interest in an entity owning real property in this state under WAC 458-61A-101.

(2) **"Consideration"** means money or anything of value, either tangible or intangible, paid or delivered, or contracted to be paid or delivered, including performance of services, in return for the transfer of real property. The term includes the amount of any lien, mortgage, contract indebtedness, or other encumbrance, given to secure the purchase price, or any part thereof, or remaining unpaid on the property at the time of sale. For example, Lee purchases a home for $250,000. He puts down $50,000, and finances the balance of $200,000. The full consideration paid for the house is $250,000.

(a) "Consideration" includes the issue of an ownership interest in any entity in exchange for a transfer of real property to the entity. For example, if Julie transfers title to 20 acres of commercial property to Smith Development, LLC in exchange for a 50% ownership interest in the company, that constitutes consideration for the transfer. In the case of partnerships, consideration includes the increase in the capital account of the partner made as a result of the partner's transfer of real property to the partnership, unless the transfer is otherwise specifically exempt under WAC 458-61A-211 or 458-61A-212.

(b) "Consideration" includes the assumption of an underlying debt on the property by the buyer at the time of transfer. For example, Ben buys a residence, valued at $300,000, from Liza. Liza was purchasing the property on a real estate contract that has an outstanding balance of $175,000. Ben gives Liza $125,000 in cash and he assumes the obligation on the real estate contract, which Liza assigns to him. Real estate excise tax is due on $300,000, which is the total consideration for the sale.

(c) "Consideration" does not include the amount of any outstanding lien or encumbrance in favor of the United States, the state, or a municipal corporation for taxes, special benefits, or improvements. For example, Mel buys residential property for $300,000. The title is encumbered by a lien for unpaid property taxes in the amount of $12,000, and a lien for municipal sidewalk improvements in the amount of $6,000. Although Mel will become liable for those liens in order to take title to the property, they are not considered part of the purchase price for the purpose of calculating real estate excise tax. The real estate excise tax is due only on the purchase price of $300,000.

(3) **"Controlling interest"** means:

(a) In the case of a corporation, either fifty percent or more of the total combined voting power of all classes of stock of the corporation entitled to vote, or fifty percent of the capital, profits, or beneficial interest in the voting stock of the corporation; and

(b) In the case of a partnership, association, trust, or other entity, fifty percent or more of the capital, profits, or beneficial interest in the partnership, association, trust, or other entity.

(4) **"County"** means the county treasurer or its agent.

(5) **"Date of sale"** means the date (normally shown on the instrument of conveyance or sale) that ownership of or title to real property, or control of the controlling interest in an entity that has a beneficial interest in real property, is delivered to the buyer/transferee in exchange for valuable consideration. In the case of a lease with option to purchase, the date of sale is the date when the purchase option is exercised and the property is transferred. "Date of sale," "date of transfer," "conveyance date," and "transaction date" all have the same meaning and may be used interchangeably in this chapter. The real estate excise tax is due on the date of sale.

(6) **"Department"** means the department of revenue.

(7) **"Domestic partner"** ((~~means one of two adults who are "state registered domestic partners" as defined in RCW 26.60.020~~)) has the same meaning as defined in chapter 26.60 RCW.

(8) **"Floating home"** means a building on a float used in whole or in part for human habitation as a single-family dwelling, which is not designed for self-propulsion by mechanical means or for propulsion by means of wind, and which is on the property tax rolls of the county in which it is located.

(9) **"Governmental entity"** means the United States, any agency or instrumentality of the United States, the state of Washington ("state"), any government agency, commission, college, university, or other department of the state, any political subdivision of the state, counties, any county agency, council, instrumentality, commission, office, or department, any Washington taxing district, municipal corporations of this state, and any office, council, department, or instrumentality of a Washington municipal corporation.

(10) **"Mining property"** is property containing or believed to contain metallic or nonmetallic minerals, and sold or leased under terms that require the buyer or lessee to conduct exploration or mining work thereon, and for no other purpose.

(11) **"Mobile home"** means a mobile home as defined by RCW 46.04.302.

(12) **"Mortgage"** has its ordinary meaning, and includes a "deed of trust" for the purposes of this chapter, unless the context clearly indicates otherwise. The term "underlying debt" may also be used to refer to a mortgage or other security interest.

(13) **"Park model trailer"** means a park model trailer as defined in RCW 46.04.622.

(14) **"Real estate"** or **"real property"** means any interest, estate, or beneficial interest in land or anything affixed to land, including the ownership interest or beneficial interest in any entity that owns land, or anything affixed to land, including standing timber and crops. The term includes condominiums and individual apartments for which the buyer receives a warranty deed. The term includes used mobile homes, used park model trailers, used floating homes, and improvements constructed upon leased land. The term also includes any part of an irrigation system that is underground or affixed to the land. The term does not include irrigation equipment that is above the ground or that is not affixed to land. See RCW 82.12.020 for the tax treatment of sales of irrigation equipment that is not included in the definition of "real estate."

(15) **"Real estate contract"** or **"contract"** means any written agreement for the sale of real property in which legal title to the property is retained by the seller as security for the payment of the purchase price. The term does not include earnest money agreements or options to purchase real property.

(16) **"Sale"** means:

(a) Any conveyance, grant, assignment, quitclaim, or transfer of the ownership of or title to real property, including standing timber, or any estate or interest therein for a valuable consideration, and any contract for such a conveyance, grant, assignment, quitclaim, or transfer, and any lease with an option to purchase real property, including standing timber, or any estate or interest therein or other contract under which possession of the property is given to the purchaser, or any other person at the purchaser's direction, and title to the property is retained by the vendor as security for the payment of the purchase price. The term includes the grant, relinquishment, or assignment of a life estate in property. The term also includes the grant, assignment, quitclaim, sale, or transfer of improvements constructed upon leased land.

(b) The term "sale" also includes the transfer or acquisition within any twelve-month period of a controlling interest in any entity with an interest in real property located in this state for a valuable consideration. For the purposes of this chapter, all acquisitions of persons acting in concert are aggregated for the purpose of determining whether a transfer or acquisition of a controlling interest has taken place. For purposes of establishing the applicable twelve-month period for a transfer or acquisition pursuant to the exercise of an option, see WAC 458-61A-101.

(c) The term "sale" also applies to successive sales of the same property. An owner of real property is subject to payment of the real estate excise tax upon the entry of each successive contract for the sale of the same parcel of property. For example, Bob owns a house that he sells to Sam on a real estate contract. Real estate excise tax is paid on the transfer from Bob to Sam. Sam makes several payments, until he becomes unemployed. Since Sam can no longer make payments on the property, he conveys it back to Bob. Bob then makes a subsequent sale of the house to Sally. Real estate excise tax is due on the transfer from Bob to Sally. See WAC 458-61A-209 for the tax implications on the conveyance from Sam back to Bob.

(d) The term "sale" does not include:

(i) Those real property transfers that are excluded from the definition of "sale" and exempted from the real estate excise tax under RCW 82.45.010(3) and this chapter, including transfers without valuable consideration.

(ii) The transfer of lots or graves in an established cemetery. An established cemetery is one that meets the requirements for ad valorem property tax exemption under chapter 84.36 RCW.

(iii) The transfer of an interest in real property merely to secure a debt or the assignment of a security interest, release of a security interest, satisfaction of a mortgage, or reconveyance under the terms of a mortgage or deed of trust.

(iv) A deed given to a purchaser under a real estate contract upon fulfillment of the terms of the contract provided that the proper tax was paid on the original transaction. The fulfillment deed must be stamped by the county treasurer as required by WAC 458-61A-301, and the stamp must show the affidavit number of the sale for which the deed is fulfilling.

(v) A qualified sale of a manufactured/mobile home community, as defined in RCW 59.20.030, that takes place on or after June 12, 2008, but before December 31, 2018.

(e) **Examples.** The following examples, while not exhaustive, illustrate some of the circumstances in which a transfer may or may not be taxable. These examples should be used only as a general guide. The status of each situation must be determined after a review of all of the facts and circumstances.

(i) John paid off his home mortgage and wants to get a loan to make improvements and buy a new car. John obtains an equity loan, secured by his home as collateral. This transaction is not subject to the real estate excise tax.

(ii) Bob purchased real property from Sam pursuant to a real estate contract. Real estate excise tax was paid on the purchase price at the time of the sale. Bob has now paid off the property, and Sam is issuing a fulfillment deed to Bob indicating that the real estate contract has been satisfied. The fulfillment deed from Sam to Bob is not subject to the real estate excise tax.

(iii) Diane has made the final payment on her mortgage, and the bank issues a full reconveyance of her property, indicating that the mortgage is paid in full. The reconveyance is not subject to the real estate excise tax.

(iv) Bill is refinancing his mortgage for a lower interest rate. There is a balloon payment on the new loan that will require that he refinance again in five years. Neither transaction is subject to the real estate excise tax.

(17) **"Seller"** means any individual, receiver, assignee, trustee for a deed of trust, trustee in bankruptcy, trust, estate, firm, partnership, joint venture, club, company, joint stock company, limited liability company, business trust, municipal corporation, quasi municipal corporation, association, society, or any group of individuals acting as a unit, whether mutual, cooperative, fraternal, nonprofit or otherwise, but it does not include the United States or the state of Washington. The term "grantor" is used interchangeably with the term "seller" in this chapter and has the same meaning for purposes of the real estate excise tax.

(18) **"Selling price"** means the true and fair value of the property conveyed. There is a rebuttable presumption that the true and fair value is equal to the total consideration paid or contracted to be paid to the seller or to another person for the seller's benefit.

(a) When the price paid does not accurately reflect the true and fair value of the property, one of the following methods may be used to determine the true and fair value:

(i) A fair market appraisal of the property; or

(ii) An allocation of assets by the seller and the buyer made under section 1060 of the Internal Revenue Code of 1986, as amended.

(b) When the true and fair value of the property at the time of sale cannot reasonably be determined by either of the methods in (a) of this subsection, the market value assessment for the property maintained in the county property tax rolls at the time of sale will be used as the selling price. RCW 82.45.030.

(c) When the sale is of a partial interest in real property, the principal balance of any debt remaining unpaid at the time of sale will be multiplied by the percentage of ownership transferred, and that amount added to any other consideration to determine the selling price.

(d) In the case of a lease with option to purchase, the selling price is the true and fair value of the property conveyed at the time the option is exercised.

AMENDATORY SECTION (Amending WSR 05-23-093, filed 11/16/05, effective 12/17/05)

WAC 458-61A-107 Option to purchase. (1) **Introduction.** The real estate excise tax applies to a conveyance of real property upon the exercise of an option to purchase.

(2) **Taxability of sales of options.** The real estate excise tax does not apply to the grant or sale of an option and the real estate excise tax affidavit is not required for that transaction. However, the sale of an option is subject to business and occupation tax under the service and other category and should be reported on the combined excise tax return. RCW 82.04.290.

(3) Effective May 1, 2010, for the sole purpose of determining whether a transfer or acquisition of a controlling interest pursuant to the exercise of an option occurred within a twelve-month period, the date on which the option agreement was executed is deemed to be the date of the transfer or acquisition. For any other purpose; however, the date on which the option is exercised is the date of the transfer or acquisition. RCW 82.45.010 (2)(b). See WAC 458-61A-101.

(4) **Examples.**

(a) Joe acquires an option at a cost of $100,000. The option, if exercised, allows Joe to purchase ten parcels of land for $700,000. As individual parcels, these lots of land are uneconomical to develop. Joe "packages" the land, making it economically feasible to develop by either obtaining sufficient acreage or required studies. Buildup, a real estate development and construction company, purchases Joe's option on the property for $2.3 million and subsequently exercises the option, paying $700,000 for the land. The real estate excise tax does not apply to the sale of the option, however the $2.3 million received for the option is subject to the business and occupation tax under the service and other category. The measure of the real estate excise tax is the $700,000 purchase price paid on the transfer of the land.

(b) Consider the same initial facts as in the example in (a) of this subsection, but instead, Joe exercises the option, and subsequently sells the land to Buildup. The real estate excise tax applies to both the transfer to Joe and the subsequent transfer from Joe to Buildup.

AMENDATORY SECTION (Amending WSR 05-23-093, filed 11/16/05, effective 12/17/05)

WAC 458-61A-301 Payment of tax, collection responsibility, audit responsibility, and tax rulings. (1) **Tax imposed.**

(a) The taxes imposed are due at the time the sale occurs and are collected by the county when the documents of sale are presented for recording or, in the case of a transfer of a controlling interest (see WAC 458-61A-101), by the department.

(b) The tax is imposed upon the seller. Effective May 1, 2010, the parent corporation of a wholly owned subsidiary is the seller, if the subsidiary sells to a third party and the subsidiary is dissolved before paying the tax.

(2) **Payment of tax. Scope of section.** This section applies to sales of real property that are evidenced by conveyance, deed, grant, assignment, quitclaim, or transfer of title to real property. See WAC 458-61A-101 for procedures pertaining to transfers or acquisitions of a controlling interest in an entity owning real property in Washington.

(3) **County as agent for state.** Real estate excise tax is paid to and collected by the agent of the county where the property is located (unless the transaction involves the transfer of a controlling interest, in which case the tax is paid to the department).

(4) **Computation of tax.** The tax is computed by multiplying the combined state and local tax rates in effect at the time of sale by the selling price. A current list of the current state and local real estate excise tax rates is available on the department's web site at dor.wa.gov. This information is also available by contacting the county where the property is located.

(5) **Evidence of payment.** The county agent stamps the instrument of sale or conveyance prior to its recording as evidence that the tax has been paid or that an exemption from the tax was claimed. In the case of a used mobile home, the real estate excise tax affidavit is stamped as evidence of payment or a claimed exemption. The stamp references the affidavit number, date, and payment of or exemption from tax, and identifies the person stamping the instrument or affidavit.

(6) **Compliance with property tax statutes.** The county agent will not stamp the instrument of conveyance or affidavit if:

(a) A continuance of use has been applied for but not approved by the county assessor under chapter 84.33 or 84.34 RCW; or

(b) Compensating or additional tax is due but has not been paid as required by RCW 84.33.086, 84.33.140 (5)(c), 84.34.108 (1)(c), 84.36.812, or 84.26.080.

(7) **Prerequisites to recording.** The county auditor will not file or record the instrument of conveyance until all taxes due under this section have been paid or the transfer is determined to be exempt from tax as indicated by a stamped document.

(8) **Evidence of lien satisfaction.** A receipt issued by the county agent for payment of the tax may be used as evidence of satisfaction of a lien imposed under RCW 82.45.070.

(9) **Audit authority.** All transactions are subject to audit by the department. The department will audit transactions to confirm the proper amount of tax was paid and that any claim for exemption is valid. Failure to provide documentation to the department as requested may result in denial of any exemptions claimed and the assessment of additional tax.

(10) **Tax assessments.**

(a) If the department discovers an underpayment of tax due, it will notify the taxpayer and assess the additional tax due, together with all applicable interest and penalties. The assessment notice will identify the additional tax due and explain the reason for the assessment.

(b) Persons receiving an assessment must respond within thirty days from the date the assessment was mailed. Failure to respond may result in the assessment of additional penalties and interest and enforcement for collection of the deficient tax under the administrative provisions of chapters 82.32 and 82.45 RCW.

(11) **Tax rulings.** Any person may request a written opinion from the department regarding their real estate excise tax liability pertaining to a proposed transfer of real property or a proposed transfer or acquisition of the controlling interest in an entity with an interest in real property. The request should include sufficient facts about the transaction to enable the department to ascertain the proper tax liability. The department will advise the taxpayer in writing of its opinion. The opinion is binding upon both the taxpayer and the department under the facts presented in accordance with WAC 458-20-100(9), appeals, small claims and settlements. To obtain a written opinion, send your request to:

Department of Revenue
Taxpayer Information & Education
P.O. Box 47478
Olympia, WA 98504-7478

You may also use the "contact" information available online at dor.wa.gov.

(12) **Refunds.**

(a) **Introduction.** Under certain circumstances, taxpayers (or their authorized representatives) may request a refund of real estate excise tax paid. The request must be filed within four years of the date of sale, and must be accompanied by supporting documents.

(b) **Claims for refunds.** Any person having paid the real estate excise tax in error may apply for a refund of the amount overpaid by submitting a completed refund request form.

(c) Forms and documentation. Refund request forms are available from the department or the county. The completed form along with supporting documentation is submitted to the county office where the tax was originally paid. If the tax was originally paid directly to the department, the claim form and supporting documentation are submitted to:

Department of Revenue
Miscellaneous Tax Section
P.O. Box 47477
Olympia, WA 98504-7477

(d) **Circumstances under which refunds are authorized.** The authority to issue a refund under this chapter is limited to the following circumstances:

(i) Real estate excise tax was paid on the conveyance back to the seller in a transaction that is completely rescinded (as defined in WAC 458-61A-209);

(ii) Real estate excise tax was paid on the conveyance back to the seller on a sale rescinded by court order. The county treasurer must attach a copy of the court decision to the department's affidavit copy (see also WAC 458-61A-208, Deeds in lieu of foreclosure);

(iii) Real estate excise tax was paid on the initial conveyance recorded in error by an escrow agent before the closing date, provided that the property is conveyed back to the seller;

(iv) Real estate excise tax was paid on the conveyance back to the seller in accordance with (d)(iii) of this subsection;

(v) Real estate excise tax was paid on the initial conveyance recorded before a purchaser assumes an outstanding loan that represents the only consideration paid for the property, provided:

(A) The purchaser is unable to assume the loan; and

(B) The property is conveyed back to the seller. The refund is allowed because there is a failure of the consideration;

(vi) The conveyance back to the seller in (d)(v) of this subsection;

(vii) Double payment of the tax;

(viii) Overpayment of the tax through error of computation; or

(ix) Real estate excise tax paid when the taxpayer was entitled to claim a valid exemption from the tax but failed to do so at the time of transfer.

(e) **Responsibilities of county.**

(i) **Request for refund made prior to disposition of proceeds.** If the taxpayer submits a valid refund request to the county before the county treasurer has remitted the tax to the state treasurer, the county may void the receipted affidavit copies and issue the refund directly. The county will then submit a copy of the initial affidavit, together with a copy of the refund request, to the department. If, after reviewing the request for refund and supporting documentation, the county is unable to determine the validity of the request, the county will send the request, a copy of the affidavit, and all supporting documentation to the department for determination. If the county denies the request for refund, in whole or in part, the taxpayer may appeal in writing to the department's miscellaneous tax section within thirty days of the county's denial.

(ii) **Request for refund made after disposition of proceeds.** If the taxpayer submits the refund request after the county treasurer has remitted the tax to the state treasurer, the county will verify the information in the request and forward

it to the department with a copy of the affidavit and any other supporting documents provided by the taxpayer. The county or the department may request additional documentation to determine whether the taxpayer qualifies for a refund.