WSR 12-02-001

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 11-315—Filed December 21, 2011, 2:04 p.m., effective December 22, 2011]

Effective Date of Rule: December 22, 2011.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-52-069.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: Harvest quotas for pink scallops and spiny scallops have not been determined through a treaty and nontreaty harvest management plan. Therefore, the department must prohibit the commercial take of these species in Puget Sound for the time being. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: December 21, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-52-06900F Scallop fishery—Puget Sound. Notwithstanding the provisions of WAC 220-52-069, effective December 22, 2011, until further notice, it is unlawful to take or possess pink scallops and spiny scallops for commercial purposes in waters of Puget Sound.

WSR 12-02-008

EMERGENCY RULES

HEALTH CARE AUTHORITY

(Medicaid Program)

[Filed December 23, 2011, 9:31 a.m., effective December 24, 2011]

Effective Date of Rule: December 24, 2011.

Purpose: Upon order of the governor, the health care authority (HCA) reduced its budget expenditures for fiscal year 2011 by 6.3 percent. To achieve the expenditure reduction required under EO 10-04, HCA eliminated dental-related services from program benefit packages for clients twenty-one years of age and older and clients receiving medical care services under the disability lifeline (DL) and Alcohol and Drug Abuse Treatment and Support Act (ADATSA) programs. Clients classified as developmentally disabled under RCW 71A.10.020 who are twenty-one years of age and older will continue to receive dental-related services under chapter 182-535 WAC.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-535-1065, 182-535-1247, 182-535-1255, 182-535-1257, 182-535-1259, 182-535-1261, 182-535-1263, 182-535-1266, 182-535-1267, 182-535-1269, 182-535-1271 and 182-535-1280; and amending WAC 182-535-1060, 182-535-1079, 182-535-1080, 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, 182-535-1090, 182-535-1092, 182-535-1094, 182-535-1096, 182-535-1098, 182-535-1099, 182-535-1100, 182-535-1220, 182-535-1350, 182-535-1400, 182-535-1450, and 182-535-1500.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Section 209(1), chapter 37, Laws of 2010 (ESSB 6444); sections 201 and 209, chapter 564, Laws of 2009 (ESHB 1244).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required HCA and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3 percent. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments.

The immediate adoption of these cuts to optional services is necessary to maintain the mandatory medicaid services for the majority of HCA clients. This rule filing contin-

ues the emergency rule adopted under WSR 11-18-011 on August 25, 2011, and WSR 11-18-065 on September 2, 2011, and complies with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011 with respect to dental services. CR-101s were filed under WSR 09-14-093 on June 30, 2009, and WSR 10-20-160 on October 6, 2010. HCA plans on filing a CR-102 in January 2012 and to formally adopt the permanent rule shortly thereafter.

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 19, Repealed 12.

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 19, Repealed 12.

Date Adopted: December 23, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1060 Clients who are eligible for dental-related services. (1) The ((~~following~~)) clients ((~~who receive services under the medical assistance programs listed~~)) described in this section are eligible ((~~for covered~~)) to receive the dental-related services((~~, subject to the restrictions and specific limitations~~)) described in this chapter ((~~and other applicable WAC:~~

~~(1) Children eligible for the~~)), subject to limitations, restrictions, and client-age requirements identified for a specific service.

(a) Clients who are eligible under one of the following medical assistance programs:

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

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

~~(c) Limited casualty program -~~))

(iii) Medically needy program (((~~LCP -~~))MNP);

(iv) Disability lifeline (DL) or Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

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

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

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

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

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

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

~~(4)~~)) (b) Clients who are eligible under one of the medical assistance programs in subsection (a) of this section and are one of the following:

(i) Twenty years of age and younger;

(ii) Twenty years of age and younger enrolled in ((~~a~~)) an agency-contracted managed care ((~~plan are eligible for medical assistance administration (MAA) covered dental services that are not covered by their plan,~~)) organization (MCO). MCO clients are eligible under fee-for-service for covered dental-related services not covered by their MCO plan, subject to the provisions of this chapter ((~~388-535 WAC~~)) and other applicable ((~~WAC~~)) agency rules;

(iii) For dates of service on and after July 1, 2011, clients who are verifiably pregnant;

(iv) For dates of service on and after July 1, 2011, clients residing in one of the following:

(A) Nursing home.

(B) Nursing facility wing of a state veteran's home.

(C) Privately operated intermediate care facility for the intellectually disabled (ICF/ID).

(D) State-operated residential habilitation center (RHC);

(v) For dates of service on and after July 1, 2011, clients who are eligible under an Aging and Disability Services Administration (ADSA) 1915(c) waiver program;

(vi) For dates of service prior to October 1, 2011, clients of the division of developmental disabilities; or

(vii) For dates of service on and after October 1, 2011, clients of the division of developmental disabilities who also qualify under (b)(i), (iii), (iv), or (v) of this subsection.

(2) See WAC 388-438-0120 for rules for clients eligible under an alien emergency medical program.

(3) The dental services discussed in this chapter are excluded from the benefit package for clients not mentioned in subsection (1) of this section. Clients who do not have these dental services in their benefit package may be eligible for the emergency oral healthcare benefit according to WAC 182-531-1025.

(4) Services announced in the agency's numbered memoranda as discontinued as part of the legislature's budget reductions are excluded from the client's benefit package.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1079 Dental-related services ((~~for clients through age twenty~~)) — General. (1) Clients described in WAC 182-535-1060 are eligible to receive the dental-related services described in this chapter, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service. The ((~~department~~)) agency pays for dental-related services and procedures provided to eligible clients ((~~through age twenty~~)) when the services and procedures:

(a) Are part of the client's dental benefit package;

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

(((~~(b)~~))) (c) Are medically necessary;

(((~~(c)~~))) (d) Meet the ((~~department's~~)) agency's prior authorization requirements, if any;

(((~~(d)~~))) (e) Are documented in the client's record in accordance with chapter ((~~388-502~~)) 182-502 WAC;

(((~~(e)~~))) (f) Are within accepted dental or medical practice standards;

(((~~(f)~~))) (g) Are consistent with a diagnosis of dental disease or condition;

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

(((~~(h)~~))) (i) Are listed as covered in the ((~~department's published~~)) agency's rules((~~,~~)) and published billing instructions and fee schedules.

(2) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:

(a) A client is not a client of the division of developmental disabilities according to WAC 182-535-1099;

(b) A client is nine years of age or older;

(c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and

(d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

(3) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

(4) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients ((~~ages~~)) twenty years of age and younger may be eligible for dental-related services listed as noncovered.

((~~(3) Clients who are eligible for services through the division of developmental disabilities may receive dental-related services according to WAC 388-535-1099.~~

(~~4~~))) (5) The ((~~department~~)) agency evaluates a request for dental-related services that are:

(a) ((~~That are~~)) In excess of the dental program's limitations or restrictions, according to WAC ((~~388-501-0169~~)) 182-501-0169; and

(b) ((~~That are~~)) Listed as noncovered, according to WAC ((~~388-501-0160~~)) 182-501-0160.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1080 Covered dental-related services ((~~for clients through age twenty~~))—Diagnostic. ((~~The department covers medically necessary dental-related diagnostic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Clinical oral evaluations.** The ((~~department~~)) agency covers:

(a) Oral health evaluations and assessments.

(b) Periodic oral evaluations as defined in WAC ((~~388-535-1050~~)) 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(c) Limited oral evaluations as defined in WAC ((~~388-535-1050~~)) 182-535-1050, only when the provider performing the limited oral evaluation is not providing routine scheduled dental services for the client. The limited oral evaluation:

(i) Must be to evaluate the client for a:

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

(ii) When performed by a denturist, is limited to the initial examination appointment. The ((~~department~~)) agency does not cover any additional limited examination by a denturist for the same client until three months after a removable prosthesis has been seated.

(d) Comprehensive oral evaluations as defined in WAC ((~~388-535-1050~~)) 182-535-1050, once per client, per provider or clinic, as an initial examination. The ((~~department~~)) agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

(e) Limited visual oral assessments as defined in WAC ((~~388-535-1050~~)) 182-535-1050, up to two per client, per year, per provider only when the assessment is:

(i) Not performed in conjunction with other clinical oral evaluation services;

(ii) Performed by a licensed dentist or dental hygienist to determine the need for sealants or fluoride treatment and/or when triage services are provided in settings other than dental offices or clinics; and

(iii) Provided by a licensed dentist or licensed dental hygienist.

(2) **Radiographs (X rays).** The ((~~department~~)) agency:

(a) Covers radiographs that are of diagnostic quality, dated, and labeled with the client's name. The ((~~department~~)) agency requires:

(i) Original radiographs to be retained by the provider as part of the client's dental record((~~,~~)); and

(ii) Duplicate radiographs to be submitted:

(A) With requests for prior authorization ((~~requests, or~~)); and

(B) When the agency requests copies of dental records ((~~are requested~~)).

(b) Uses the prevailing standard of care to determine the need for dental radiographs.

(c) Covers an intraoral complete series (includes four bitewings), once in a three-year period only if the ((~~department~~)) agency has not paid for a panoramic radiograph for the same client in the same three-year period.

(d) Covers periapical radiographs that are not included in a complete series (incomplete radiographs), once in a three-year period. Documentation supporting the medical necessity for these must be included in the client's record. The agency

limits reimbursement for all incomplete radiographs to a total payment of no more than the payment for a complete series.

(e) Covers an occlusal intraoral radiograph once in a two-year period((. Documentation supporting the medical necessity for these must be included in the client's record)), for clients twenty years of age and younger.

(f) Covers ((a maximum of four bitewing radiographs once every twelve months for clients through age eleven)) oral facial photo images, only on a case-by-case basis when requested by the agency, for clients twenty years of age and younger.

(g) Covers a maximum of four bitewing radiographs once every twelve months ((for clients ages twelve through twenty)).

(h) Covers panoramic radiographs in conjunction with four bitewings, once in a three-year period, only if the ((department)) agency has not paid for an intraoral complete series for the same client in the same three-year period.

(i) May ((cover)) reimburse for panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized.

(j) Covers cephalometric films((:

(i))) once in a two-year period for clients twenty years of age and younger, only on a case-by-case basis and when prior authorized.

For orthodontic((s)) services, ((as described in)) see chapter ((388-535A)) 182-535A WAC((; or

(ii) Only on a case-by-case basis and when prior authorized)).

(k) Covers radiographs not listed as covered in this subsection, only on a case-by-case basis and when prior authorized.

(l) Covers oral and facial photographic images, only on a case-by-case basis and when requested by the ((department)) agency.

(3) **Tests and examinations.** The ((department)) agency covers the following for clients who are twenty years of age and younger:

(a) One pulp vitality test per visit (not per tooth):

(i) For diagnosis only during limited oral evaluations; and

(ii) When radiographs and/or documented symptoms justify the medical necessity for the pulp vitality test.

(b) Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis, and when requested by the ((department)) agency.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1082 Covered dental-related services ((for clients through age twenty)) —Preventive services. Clients described in WAC 182-535-1060 are eligible for the ((department covers medically necessary)) dental-related preventive services((, subject to the coverage limitations)) listed in this section, ((for clients through age twenty as follows:)) subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Dental prophylaxis.** The ((department)) agency covers prophylaxis as follows. Prophylaxis:

(a) ((Which)) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary((, transitional,)) or permanent dentition((, once every six months for clients through age twenty)).

(b) Is limited to once every:

(i) Six months for clients eighteen years of age and younger; and

(ii) Twelve months for clients nineteen years of age and older.

(c) Is reimbursed only when the service is performed:

(i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients ((ages)) from thirteen ((through twenty)) to eighteen years of age; and

(ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.

(((c) Only)) (d) Is not reimbursed separately when ((not)) performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.

(((d))) (e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC ((388-535-1099)) 182-535-1099.

(2) **Topical fluoride treatment.** The ((department)) agency covers:

(a) Fluoride ((varnish,)) rinse, foam or gel, for clients ((ages)) six years of age and younger, up to three times within a twelve-month period.

(b) Fluoride ((varnish,)) rinse, foam or gel, for clients ((ages)) from seven ((through)) to eighteen years of age, up to two times within a twelve-month period.

(c) Fluoride ((varnish,)) rinse, foam or gel, up to three times within a twelve-month period during orthodontic treatment.

(d) Fluoride rinse, foam or gel, for clients ((ages)) from nineteen ((through twenty)) to sixty-four years of age, once within a twelve-month period.

(e) Fluoride rinse, foam or gel, for clients sixty-five years of age and older who reside in alternate living facilities, up to three times within a twelve-month period.

(f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(((f))) (g) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC ((388-535-1099)) 182-535-1099.

(3) **Oral hygiene instruction.** The ((department)) agency covers:

(a) Oral hygiene instruction only for clients ((through age)) eight years of age and younger.

(b) Oral hygiene instruction up to two times within a twelve-month period.

(c) Individualized oral hygiene instruction for home care to include tooth brushing technique, flossing, and use of oral hygiene aides.

(d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.

(e) Oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

(4) **Sealants.** The ((~~department~~)) agency covers:

(a) Sealants only when used on a mechanically and/or chemically prepared enamel surface.

(b) Sealants once per tooth:

(i) In a three-year period for clients ((~~through age~~)) eighteen years of age and younger; and

(ii) In a two-year period for clients any age of the division of developmental disabilities according to WAC 182-535-1099.

(c) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(d) Sealants on noncarious teeth or teeth with incipient caries.

(e) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(f) Additional sealants not described in this subsection on a case-by-case basis and when prior authorized.

(5) **Space maintenance.** The ((~~department covers~~)) agency:

(a) Covers fixed unilateral or fixed bilateral space maintainers for clients ((~~through age eighteen~~)) twelve years of age and younger, subject to the following:

(i) Only one space maintainer is covered per quadrant.

(ii) Space maintainers are covered only for missing primary molars A, B, I, J, K, L, S, and T.

(iii) Replacement space maintainers are covered only on a case-by-case basis and when prior authorized.

(b) ((~~Only one space maintainer per quadrant.~~

~~(c) Space maintainers only for missing primary molars A, B, I, J, K, L, S, and T.~~

~~(d) Replacement space maintainers only on a case-by-case basis and when prior authorized.~~)) Covers removal of fixed space maintainers for clients eighteen years of age and younger.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1084 Covered dental-related services ((~~for clients through age twenty~~)) —Restorative services. ((~~The department covers medically necessary dental-related restorative services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

~~(a) Clients ages eight and younger;~~

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

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

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

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

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

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

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

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

((~~(3)~~)) (2) **Amalgam restorations for primary posterior teeth only.** The ((~~department~~)) agency covers amalgam restorations for a maximum of two surfaces for a primary first molar and maximum of three surfaces for a primary second molar. (See subsection ((~~(9)~~)) (10)(c) of this section for restorations for a primary posterior tooth requiring additional surfaces.) The ((~~department~~)) agency does not pay for additional amalgam restorations.

((~~(4)~~)) (3) **Amalgam restorations for permanent posterior teeth only.** The ((~~department~~)) agency:

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

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

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

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

((~~(5)~~)) (4) **Resin-based composite restorations for primary and permanent teeth.** The ((~~department~~)) agency:

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

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

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

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentoenamel junction (DEJ) to be sealants (see WAC ((~~388-535-1082~~)) 182-535-1082(4) for sealants coverage).

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

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

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

((~~(6)~~)) (5) **Resin-based composite restorations for primary teeth only.** The ((~~department~~)) agency covers:

(a) Resin-based composite restorations for a maximum of three surfaces for a primary anterior tooth (see subsection ((~~(9)~~)) (10)(b) of this section for restorations for a primary anterior tooth requiring a four or more surface restoration). The ((~~department~~)) agency does not pay for additional composite or amalgam restorations on the same tooth after three surfaces.

(b) Resin-based composite restorations for a maximum of two surfaces for a primary first molar and a maximum of three surfaces for a primary second molar. (See subsection ((~~(9)~~)) (10)(c) of this subsection for restorations for a primary posterior tooth requiring additional surfaces.) The ((~~department~~)) agency does not pay for additional composite restorations on the same tooth.

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

((~~(7)~~)) (6) **Resin-based composite restorations for permanent teeth only.** The ((~~department~~)) agency covers:

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

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

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

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

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

((~~(8)~~)) (7) The agency reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(8) The agency reimburses multiple restorations that do not involve the proximal and occlusal surfaces of the same tooth as a single multi-surface restoration.

(9) **Crowns.** The ((~~department~~)) agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients ((~~ages~~)) from twelve ((~~through~~)) to twenty years of age when the crowns meet prior authorization criteria in WAC ((~~388-535-1220~~)) 182-535-1220 and the provider follows the prior authorization requirements in ((~~(d)~~)) (c) of this subsection:

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

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

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

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

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The ((~~department~~)) agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

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

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

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

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

(viii) Local anesthesia.

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

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

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

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

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

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

(((~~(9)~~))) (10) **Other restorative services.** The ((~~department~~)) agency covers the following restorative services:

(a) All recementations of permanent indirect crowns only for clients from twelve to twenty years of age.

(b) Prefabricated stainless steel crowns with resin window, resin-based composite crowns, prefabricated esthetic coated stainless steel crowns, and fabricated resin crowns for primary anterior teeth once every three years:

(i) Only for clients from twelve to twenty years of age; and

(ii) Without prior authorization if the tooth requires a four or more surface restoration.

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

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

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

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns for permanent posterior teeth once every three years ((~~when~~)), for clients twenty years of age and younger, without prior ((~~authorized~~)) authorization.

(e) Prefabricated stainless steel crowns for clients of the division of developmental disabilities without prior authorization according to WAC ((~~388-535-1099~~)) 182-535-1099.

(f) Core buildup, including pins, only on permanent teeth, only for clients twenty years of age and younger, and only when prior authorized at the same time as the crown prior authorization.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients twenty years of age and younger, and only when prior authorized at the same time as the crown prior authorization.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1086 Covered dental-related services ((~~for clients through age twenty~~)) —Endodontic services. ((~~The department covers medically necessary dental related endodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related endodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Pulp capping.** The ((~~department~~)) agency considers pulp capping to be included in the payment for the restoration.

(2) **Pulpotomy.** The ((~~department~~)) agency covers:

(a) Therapeutic pulpotomy on primary posterior teeth only((~~; and~~)) for clients twenty years of age and younger.

(b) Pulpal debridement on permanent teeth only, excluding teeth one, sixteen, seventeen, and thirty-two. The ((~~department~~)) agency does not pay for pulpal debridement when performed with palliative treatment of dental pain or when performed on the same day as endodontic treatment.

(3) **Endodontic treatment.** The ((~~department~~)) agency:

(a) Covers endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment.

(b) Covers endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two for clients twenty years of age and younger.

(c) Considers the following included in endodontic treatment:

(i) Pulpectomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

(iii) All intra-operative and final evaluation radiographs for the endodontic procedure.

(d) Pays separately for the following services that are related to the endodontic treatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(e) ((~~Requires~~)) Covers endodontic retreatment for clients twenty years of age and younger when prior ((~~authorization for endodontic retreatment and~~)) authorized.

(f) The agency considers endodontic retreatment to include:

(i) The removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals;

(ii) Placement of new filling material; and

(iii) Retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth one, sixteen, seventeen, and thirty-two.

(((~~f~~))) (g) Pays separately for the following services that are related to the endodontic retreatment:

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

(iii) Post treatment evaluation radiographs if taken at least three months after treatment.

(((~~g~~))) (h) Does not pay for endodontic retreatment when provided by the original treating provider or clinic unless prior authorized by the ((~~department~~)) agency.

(((~~h~~))) (i) Covers apexification for apical closures for anterior permanent teeth only on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three interim treatment visits and limited to clients twenty years of age and younger.

(((~~i~~))) (j) Covers apicoectomy and a retrograde fill for anterior teeth only for clients twenty years of age and younger.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1088 Covered dental-related services ((~~for clients through age twenty~~)) —Periodontic services. ((~~The department covers medically necessary periodontic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the dental-related peri-

odontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

(1) **Surgical periodontal services.** The ((~~department~~)) agency covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty only on a case-by-case basis and when prior authorized and only for clients twenty years of age and younger; and

(b) Gingivectomy/gingivoplasty for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

(2) **Nonsurgical periodontal services.** The ((~~department~~)) agency:

(a) Covers periodontal scaling and root planing for clients from thirteen to eighteen years of age, once per quadrant, per client, in a two-year period, on a case-by-case basis, when prior authorized ((~~for clients ages thirteen through eighteen~~)), and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least twelve calendar months from the completion of periodontal maintenance.

(b) Covers periodontal scaling and root planing once per quadrant, per client, in a two-year period for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(d) Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(e) Covers periodontal scaling and root planing for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

(3) **Other periodontal services.** The ((~~department~~)) agency:

(a) Covers periodontal maintenance for clients from thirteen to eighteen years of age once per client in a twelve-month period on a case-by-case basis, when prior authorized, ((~~for clients ages thirteen through eighteen,~~)) and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) ((~~Performed at least~~)) The client has had periodontal scaling and root planing but not within twelve months ((~~from~~)) of the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a twelve month period for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed ((~~on a different date of service as~~)) at least twelve calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the division of developmental disabilities according to WAC ((~~388-535-1099~~)) 182-535-1099.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1090 Covered dental-related services ((~~for clients through age twenty~~))—Prosthodontics (removable). ((~~The department covers medically necessary prosthodontics (removable) services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures((~~, except as stated in (e)(ii)(B) of this subsection~~)). Prior authorization requests must meet the criteria in WAC ((~~388-535-1220~~)) 182-535-1220. In addition, the ((~~department~~)) agency requires the dental provider to submit:

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

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

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

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

(b) Covers complete dentures, as follows:

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

(ii) An immediate denture for clients twenty years of age and younger when prior authorized.

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

(((~~iii) Replacement~~)) (iv) Reline of an immediate denture with a complete denture is covered for clients twenty years of age and younger, if the ((~~complete denture~~)) reline is prior authorized at least six months after the seat date of the immediate denture.

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

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

(vii) Complete dentures for clients twenty-one years of age and older are limited to:

(A) One initial maxillary complete denture and one initial mandibular complete denture per client, per the client's lifetime; and

(B) One replacement maxillary complete denture and one replacement mandibular complete denture per client, per client's lifetime.

(c) Covers partial dentures, as follows:

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

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

(B) The client has established caries control;

(C) One or more anterior teeth are missing or four or more posterior teeth are missing (excluding teeth one, two, fifteen, sixteen, seventeen, eighteen, thirty-one, and thirty-two);

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

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

(ii) Prior authorization ((~~of~~)) is required for partial dentures((~~:~~

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

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

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

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

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

(i) Cast-metal framework with resin-based partial dentures, including any conventional clasps, rests, and teeth, are covered for clients ((~~ages~~)) from eighteen ((~~through~~)) to twenty years of age:

(A) Only once in a five-year period((~~,~~));

(B) On a case-by-case basis((~~,~~));

(C) When prior authorized; and ((~~department~~))

(D) When agency coverage criteria listed in subsection (d)(v) of this subsection are met.

(ii) Cast-metal framework partial dentures are not covered for:

(A) Clients ((~~ages~~)) seventeen years of age and younger ((~~are not covered~~)); or

(B) Clients twenty-one years of age and older.

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

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

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

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

(B) The client has established caries control;

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

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

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

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

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

(e) Does not cover replacement of a cast-metal framework partial denture, with any type of denture, within five years of the initial seat date of the partial denture.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Up to two tissue conditionings, only for clients twenty years of age and younger, and only when performed within three months after the seating date.

(e) Laboratory fees, subject to the following:

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

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

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

(B) Moves from the state;

(C) Cannot be located;

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

(E) Dies.

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1092 Covered dental-related services ((~~for clients through age twenty~~)) —Maxillofacial prosthetic services. ((~~The department covers medically necessary maxillofacial prosthetic services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the maxillofacial prosthetic services listed in this section, subject to the following:

(1) Maxillofacial prosthetics are covered only for clients twenty years of age and younger on a case-by-case basis and when prior authorized; and

(2) The ((~~department~~)) agency must preapprove a provider qualified to furnish maxillofacial prosthetics.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1094 Covered dental-related services ((~~for clients through age twenty~~)) —Oral and maxillofacial surgery services. ((~~The department covers medically necessary oral and maxillofacial surgery services,~~)) Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations ((~~listed, for clients through age twenty as follows:~~)), restrictions, and client-age requirements identified for a specific service.

(1) **Oral and maxillofacial surgery services.** The ((~~department~~)) agency:

(a) Requires enrolled providers who do not meet the conditions in WAC ((~~388-535-1070~~)) 182-535-1070(3) to bill claims for services that are listed in this subsection using only the current dental terminology (CDT) codes.

(b) Requires enrolled providers (oral and maxillofacial surgeons) who meet the conditions in WAC ((~~388-535-1070~~)) 182-535-1070(3) to bill claims using current procedural terminology (CPT) codes unless the procedure is specifically listed in the ((~~department's~~)) agency's current published billing instructions as a CDT covered code (e.g., extractions).

(c) Covers nonemergency oral surgery performed in a hospital or ambulatory surgery center only for:

(i) Clients ((~~ages~~)) eight years of age and younger;

(ii) Clients ((~~ages~~)) from nine ((~~through~~)) to twenty years of age only on a case-by-case basis and when the site-of-service is prior authorized by the agency; and

(iii) Clients any age of the division of developmental disabilities ((~~according to WAC 388-535-1099~~)).

(d) Requires the client's dental record to include supporting documentation for each type of extraction or any other surgical procedure billed to the ((~~department~~)) agency. The documentation must include:

(i) Appropriate consent form signed by the client or the client's legal representative;

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

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

(v) A surgical narrative and complete description of each service performed beyond surgical extraction or beyond code definition;

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

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

(e) Covers routine and surgical extractions.

(f) Requires prior authorization for complicated surgical extractions.

(g) Covers tooth reimplantation/stabilization of accidentally evulsed or displaced teeth for clients twenty years of age and younger.

(h) Covers surgical extraction of unerupted teeth for clients twenty years of age and younger.

(i) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The ((~~department~~)) agency

includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(((~~(g)~~))) (j) Covers ((~~biopsy, as follows~~)) the following without prior authorization:

(i) Biopsy of soft oral tissue ((~~or~~));

(ii) Brush biopsy ((~~do not require prior authorization; and~~

~~(ii)~~))) for clients twenty years of age and younger.

(k) Requires providers to keep all biopsy reports or findings ((~~must be kept~~)) in the client's dental record.

(((~~(h)~~))) (l) Covers alveoloplasty for clients twenty years of age and younger only on a case-by-case basis and when prior authorized. The ((~~department~~)) agency covers alveoplasty only when not performed in conjunction with extractions.

(((~~(i)~~))) (m) Covers surgical excision of soft tissue lesions only on a case-by-case basis and when prior authorized.

(((~~(j)~~))) (n) Covers only the following excisions of bone tissue in conjunction with placement of ((~~immediate,~~)) complete((~~,~~)) or partial dentures for clients twenty years of age and younger when prior authorized:

(i) Removal of lateral exostosis;

(ii) Removal of torus palatinus or torus mandibularis; and

(iii) Surgical reduction of soft tissue ((~~or~~)) osseous tuberosity.

(2) **Surgical incisions.** The ((~~department~~)) agency covers the following surgical incision-related services:

(a) Uncomplicated intraoral and extraoral soft tissue incision and drainage of abscess. The ((~~department~~)) agency does not cover this service when combined with an extraction or root canal treatment. Documentation supporting medical necessity must be in the client's record.

(b) Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue for clients twenty years of age and younger when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(c) Frenuloplasty/frenulectomy for clients ((~~through age~~)) six years of age and younger without prior authorization. ((~~The department covers~~))

(d) Frenuloplasty/frenulectomy for clients ((~~ages~~)) from seven ((~~through~~)) to twelve years of age only on a case-by-case and when prior authorized. Documentation supporting the medical necessity for the service must be in the client's record.

(3) **Occlusal orthotic devices.** (Refer to WAC ((~~388-535-1098 (5)~~)) 182-535-1098 (4)(c) for occlusal guard coverage and limitations on coverage.) The ((~~department~~)) agency covers:

(a) Occlusal orthotic devices for clients ((~~ages~~)) from twelve ((~~through~~)) to twenty years of age only on a case-by-case basis and when prior authorized.

(b) An occlusal orthotic device only as a laboratory processed full arch appliance.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1096 Covered dental-related services ((~~for clients through age twenty~~))—Orthodontic services. (1) The ((~~department~~)) agency covers orthodontic services, subject to the coverage limitations listed, for clients ((~~through age~~)) twenty years of age and younger, according to chapter ((~~388-535A~~)) 182-535A WAC.

(2) The agency does not cover orthodontic services for clients twenty-one years of age and older.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1098 Covered dental-related services ((~~for clients through age twenty~~))—Adjunctive general services. ((~~The department covers medically necessary dental related adjunctive general services, subject to the coverage limitations listed, for clients through age twenty as follows:~~)) Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Adjunctive general services.** The ((~~department~~)) agency:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC ((~~388-535-1086~~)) 182-535-1086 (2)(b)), for treatment of dental pain, for clients twenty years of age and younger, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office-based oral or parenteral conscious sedation, deep sedation, or general anesthesia, as follows:

(i) The provider's current anesthesia permit must be on file with the ((~~department~~)) agency.

(ii) For clients ((~~of the division of developmental disabilities, the services must be performed according to WAC 388-535-1099.~~

~~(iii) For clients ages~~)) eight years of age and younger, and for clients any age of the division of developmental disabilities, documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(((~~(iv)~~))) (iii) For clients ((~~ages~~)) from nine ((~~through~~)) to twenty years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. Oral surgery services listed in WAC ((~~388-535-1094~~)) 182-535-1094 do not require prior authorization.

(((~~(v)~~))) (iv) Prior authorization is not required for oral or parenteral conscious sedation for any dental service for clients twenty years of age and younger, and for clients any age of the division of developmental disabilities. Documentation

supporting the medical necessity of the service must be in the client's record.

((~~(vi)~~)) (v) For clients ((~~ages~~)) from nine ((~~through eighteen~~)) to twenty years of age who have a diagnosis of oral facial cleft, the ((~~department~~)) agency does not require prior authorization for deep sedation or general anesthesia services when the dental procedure is directly related to the oral facial cleft treatment.

((~~(vii) For clients through age twenty, the~~)) (vi) A provider must bill anesthesia services using the CDT codes listed in the ((~~department's~~)) agency's current published billing instructions.

(d) Covers inhalation of nitrous oxide ((~~for clients through age twenty~~)), once per day.

(e) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(f) Pays for dental anesthesia services according to WAC ((~~388-535-1350~~)) 182-535-1350.

(g) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the ((~~department~~)) agency for the services to be covered.

(2) ((**~~Nonemergency dental services.~~** ~~The department covers nonemergency dental services performed in a hospital or ambulatory surgical center only for:~~

~~(a) Clients ages eight and younger.~~

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

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

~~(3)~~)) **Professional visits.** The ((~~department~~)) agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The ((~~department~~)) agency limits payment to two facilities per day, per provider.

(b) One hospital call (visit), including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The ((~~department~~)) agency limits payment to one emergency visit per day, per client, per provider.

((~~(4)~~)) (3) **Drugs and/or medicaments (pharmaceuticals).** The ((~~department~~)) agency covers drugs and/or medicaments only when used with parenteral conscious sedation, deep sedation, or general anesthesia for clients twenty years of age and younger. The ((~~department's~~)) agency's dental program does not pay for oral sedation medications.

((~~(5)~~)) (4) **Miscellaneous services.** The ((~~department~~)) agency covers:

(a) Behavior management when the assistance of one additional dental staff other than the dentist is required((~~,~~)) for the following clients and documentation supporting the need for the behavior management must be in the client's record:

(i) Clients ((~~ages~~)) eight years of age and younger;

(ii) Clients ((~~ages~~)) from nine ((~~through~~)) to twenty years of age, only on a case-by-case basis and when prior authorized;

(iii) Clients any age of the division of developmental disabilities ((~~according to WAC 388-535-1099~~)); and

(iv) Clients who reside in an alternate living facility (ALF) as defined in WAC 388-513-1301 or in a nursing facility.

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC ((~~388-535-1094~~)) 182-535-1094(3) for occlusal orthotic device coverage and coverage limitations.) The ((~~department~~)) agency covers:

(i) An occlusal guard only for clients ((~~ages~~)) from twelve ((~~through~~)) to twenty years of age when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities. Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the ((~~department~~)) agency pays for the dental-related services listed under the categories of services ((~~listed~~)) in this section ((~~for~~)) that are provided to clients of the division of developmental disabilities((~~, subject to the coverage limitations listed~~)). Except for WAC 182-535-1065, this chapter ((~~388-535 WAC~~)) also applies to clients of the division of developmental disabilities, regardless of age, unless otherwise stated in this section.

(1) **Preventive services.**

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

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

(c) Sealants. The ((~~department~~)) agency covers sealants:

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

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

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

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

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

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

(b) For clients ((~~ages~~)) twenty-one years of age and older, the ((~~department~~)) agency requires prior authorization for stainless steel crowns when the tooth has had a pulpotomy and only for:

(i) Primary first molars when the decay involves three or more surfaces; and

(ii) Second molars when the decay involves four or more surfaces.

(3) **Periodontic services.**

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

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

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

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

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

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

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

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

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

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

(((~~ii)~~)) (b) Sedations services according to WAC ((~~388-535-1098~~)) 182-535-1098 (1)(c) and (e).

(((~~b)~~)) (5) **Nonemergency dental services.** The ((~~department~~)) agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC ((~~388-535-1082, 388-535-1084, 388-535-1086, 388-535-1088, and 388-535-1094~~)) 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(((~~5)~~)) (6) **Miscellaneous services—Behavior management.** The ((~~department~~)) agency covers behavior management provided in dental offices or dental clinics ((~~for clients of any age~~)). Documentation supporting the medical necessity of the service must be included in the client's record.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1100 Dental-related services not covered ((~~for clients through age twenty~~)). (1) The ((~~department~~)) agency does not cover the following ((~~for clients through age twenty~~)):

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. See WAC ((~~388-534-0100~~)) 182-534-0100 for information about the EPSDT program.

(b) Any service specifically excluded by statute.

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

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

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

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

(A) Washington Administrative Code (WAC).

(B) The ((~~department's~~)) agency's current published documents.

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

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

(i) Detailed and extensive oral evaluations or reevaluations.

(ii) Extraoral radiographs.

(((~~ii) Comprehensive periodontal evaluations.~~)) (iii) Posterior-anterior or lateral skull and facial bone survey films.

(iv) Any temporomandibular joint films.

(v) Tomographic surveys.

(vi) Cephalometric films, for clients twenty-one years of age and older.

(vii) Oral/facial photographic images, for clients twenty-one years of age and older.

(viii) Comprehensive periodontal evaluations.

(ix) Occlusal intraoral radiographs, for clients twenty-one years of age and older.

(x) Viral cultures, genetic testing, caries susceptibility tests, or adjunctive prediagnostic tests.

(xi) Pulp vitality tests, for clients twenty-one years of age and older.

(xii) Diagnostic casts, for clients twenty-one years of age and older.

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

(i) Nutritional counseling for control of dental disease.

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

(iii) Removable space maintainers of any type.

(iv) Oral hygiene instructions for clients nine years of age and older. This is included as part of the global fee for oral prophylaxis.

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

((~~(v)~~)) (vi) Sealants, for clients twenty years of age and older. For clients of the division of developmental disabilities, see WAC 182-535-1099.

(vii) Space maintainers, for clients ((~~ages~~)) nineteen ((~~through twenty~~)) years of age and older.

(viii) Recementation of space maintainers, for clients twenty-one years of age and older.

(ix) Fluoride trays of any type, for clients twenty-one years of age and older.

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

(i) Restorations for wear on any surface of any tooth without evidence of decay through the dentoenamel junction (DEJ) or on the root surface.

(ii) Gold foil restorations.

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

((~~(iii)~~)) (iv) Prefabricated resin crowns, for clients twenty-one years of age and older.

(v) Preventive restorations.

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

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

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

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

((~~(vii)~~)) (x) Recementation of any crown, inlay/onlay, or any other type of indirect restoration, for clients twenty-one years of age and older.

(xi) Sedative fillings.

(xii) Any type of core buildup, cast post and core, or prefabricated post and core, for clients twenty-one years of age and older.

(xiii) Any type of coping.

((~~(viii)~~)) (xiv) Crown repairs.

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

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

(i) The following endodontic services for clients twenty-one years of age and older:

(A) Endodontic therapy on permanent bicuspids;

(B) Any apexification/recalcification procedures; or

(C) Any apicoectomy/periradicular service.

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

(iii) The following endodontic services:

(A) Indirect or direct pulp caps.

(B) Any endodontic therapy on primary teeth, except as described in WAC ((~~388-535-1086~~)) 182-535-1086 (3)(a).

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

~~(iii)~~)) (C) Endodontic therapy on molar teeth.

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

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

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

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

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

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

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

(F) Guided tissue regeneration.

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

(H) Distal or proximal wedge procedures.

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

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement.

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

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

(i) Removable unilateral partial dentures.

(ii) Adjustments to any removable prosthesis.

(iii) Any interim complete or partial dentures.

((~~(iii)~~)) (iv) Flexible base partial dentures.

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

(vi) Precision attachments.

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

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

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

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

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

(h) **Fixed prosthodontics.** The ((~~department~~)) agency does not cover any type of:

(i) ((~~Any type of~~)) Fixed partial denture pontic ((~~or~~)).

(ii) Fixed partial denture retainer.

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

((~~(i)~~)) (iv) Occlusal orthotic splint or device, bruxing or grinding splint or device, temporomandibular joint splint or device, or sleep apnea splint or device.

(v) Orthodontic service or appliance, for clients twenty-one years of age and older.

(i) **Oral maxillofacial prosthetic services.** The agency does not cover any type of oral or facial prosthesis other than those listed in WAC 182-535-1092.

(j) **Oral and maxillofacial surgery.** The ((~~department~~)) agency does not cover:

(i) Any oral surgery service not listed in WAC ((~~388-535-1094~~)) 182-535-1094.

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

((~~(j)~~)) (iii) Vestibuloplasty.

(iv) Frenuloplasty/frenulectomy, for clients twenty-one years of age and older.

(k) **Adjunctive general services.** The ((~~department~~)) agency does not cover:

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

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

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

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

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

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

(A) Fabrication of an athletic mouthguard.

(B) Occlusal guards for clients twenty-one years of age and older.

(C) Nightguards.

(D) Occlusion analysis.

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

((~~(D)~~)) (F) Enamel microabrasion.

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

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

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

((~~(H)~~)) (J) Educational supplies.

((~~(I)~~)) (K) Nonmedical equipment or supplies.

((~~(J)~~)) (L) Personal comfort items or services.

((~~(K)~~)) (M) Provider mileage or travel costs.

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

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

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

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1220 Obtaining prior authorization for dental-related services ((~~for clients through age twenty~~)). (1) The ((~~department~~)) agency uses the determination process for payment described in WAC ((~~388-501-0165~~)) 182-501-0165 for covered dental-related services ((~~for clients through age twenty~~)) that require prior authorization.

(2) The ((~~department~~)) agency requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on ((~~an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611~~)) DSHS form 13-835, available on the agency's web site.

(3) The ((~~department~~)) agency may request additional information as follows:

(a) Additional radiographs (X rays) (refer to WAC ((~~388-535-1080~~)) 182-535-1080(2))((~~.~~));

(b) Study models;

(c) Photographs; and

(d) Any other information as determined by the ((~~department~~)) agency.

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

(5) When the ((~~department~~)) agency authorizes a dental-related service for a client, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The authorization is valid for six months and only if the client is eligible for covered services on the date of service.

(6) The ((~~department~~)) agency denies a request for a dental-related service when the requested service:

(a) Is covered by another ((~~department~~)) agency program;

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

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter ((~~388-535 WAC~~)).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1350 Payment methodology for dental-related services. The ((~~medical assistance administration (MAA)~~)) agency uses the description of dental services described in the American Dental Association's Current Dental Terminology, and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, ((~~MAA~~)) the agency pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC ((~~388-535-1100~~)) 182-535-1100 and ((~~388-535-1400~~)) 182-535-1400.

(2) ((~~MAA~~)) The agency sets maximum allowable fees for dental services ((~~provided to children~~)) as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(5) ((~~MAA~~)) The agency pays eligible providers listed in WAC ((~~388-535-1070~~)) 182-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1400 Payment for dental-related services. (1) The ((~~medical assistance administration (MAA)~~)) agency considers that a provider who furnishes covered dental services to an eligible client has accepted ((~~MAA's~~)) the agency's rules and fees.

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

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

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

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

(6) Participating providers must bill a client according to WAC ((~~388-502-0160~~)) 182-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC ((~~388-535-1240~~)) 182-535-1240 and ((~~388-535-1290~~)) 182-535-1290.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1450 Payment for denture laboratory services. This section applies to payment for denture laboratory services. The ((~~medical assistance administration (MAA)~~)) agency does not directly reimburse denture laboratories. ((~~MAA's~~)) The agency's reimbursement for complete dentures, ((~~immediate dentures,~~)) partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-535-1500 Payment for dental-related hospital services. The ((~~medical assistance administration (MAA)~~)) agency pays for medically necessary dental-related ((~~hospital~~)) services provided in an inpatient ((~~and~~)) or outpatient ((~~services in accord with~~)) hospital setting according to WAC ((~~388-550-1100~~)) 182-550-1100.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-535-1065	Coverage limits for dental-related services provided under the GA-U and ADATSA programs.
WAC 182-535-1247	Dental-related services for clients age twenty-one and older—General.
WAC 182-535-1255	Covered dental-related services—Adults.
WAC 182-535-1257	Covered dental-related services for clients age twenty-one and older—Preventive services.
WAC 182-535-1259	Covered dental-related services for clients age twenty-one and older—Restorative services.
WAC 182-535-1261	Covered dental-related services for clients age twenty-one and older—Endodontic services.
WAC 182-535-1263	Covered dental-related services for clients age twenty-one and older—Periodontic services.
WAC 182-535-1266	Covered dental-related services for clients age twenty-one and older—Prosthodontics (removable).
WAC 182-535-1267	Covered dental-related services for clients age twenty-one and older—Oral and maxillofacial surgery services.
WAC 182-535-1269	Covered dental-related services for clients age twenty-one and older—Adjunctive general services.
WAC 182-535-1271	Dental-related services not covered for clients age twenty-one and older.
WAC 182-535-1280	Obtaining prior authorization for dental-related services for clients age twenty-one and older.

WSR 12-02-009

EMERGENCY RULES

HEALTH CARE AUTHORITY

(Medicaid Program)

[Filed December 23, 2011, 10:21 a.m., effective December 24, 2011]

Effective Date of Rule: December 24, 2011.

Purpose: Upon order of the governor, the health care authority (HCA) reduced its budget expenditures for fiscal year 2011 and 2012 by eliminating a number of optional medical services from program benefits packages for clients twenty-one years of age and older. These medical services include vision, hearing, and dental care. Sections in chapter 182-501 WAC and WAC 182-502-0160 are being amended to reflect and support these program cuts.

Citation of Existing Rules Affected by this Order: Amending WAC 388-501-0050 [182-501-0050], 388-501-0060 [182-501-0060], 388-501-0065 [182-501-0065], 388-501-0070 [182-501-0070], and 388-502-0160 [182-502-0160].

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Chapter 564, Laws of 2011 (2E2SHB 1738).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3 percent. As a consequence of the executive order, funding for the benefits was eliminated effective January 1, 2011, as part of these regulatory amendments. HCA is proceeding with the permanent rule adoption process initiated by the CR-101 filed under WSR 10-22-12 [10-22-121] and anticipates filing the CR-102 sometime in January 2012.

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

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: December 23, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-501-0050 Healthcare general coverage. WAC ((~~388-501-0050~~)) 182-501-0050 through ((~~388-501-0065~~)) 182-501-0065 describe the healthcare services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC ((~~388-538-050~~)) 182-538-050). For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. WAC ((~~388-501-0070~~)) 182-501-0070 describes noncovered services.

(1) Healthcare service categories listed in WAC ((~~388-501-0060~~)) 182-501-0060 do not represent a contract for healthcare services.

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

(3) Under the ((~~department's~~)) agency's or the agency designee's fee-for-service programs, providers must be enrolled with the ((~~department~~)) agency or the agency's designee and meet the requirements of chapter ((~~388-502~~)) 182-502 WAC to be paid for furnishing healthcare services to clients.

(4) The ((~~department~~)) agency or the agency's designee pays only for the healthcare services that are:

(a) ((~~Within the scope of~~)) Included in the client's ((~~medical program~~)) healthcare benefits package as described in WAC 182-501-0060;

(b) Covered - See subsection (9) of this section;

(c) Ordered or prescribed by a healthcare provider who meets the requirements of chapter ((~~388-502~~)) 182-502 WAC;

(d) Medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070;

(e) Submitted for authorization, when required, in accordance with WAC ((~~388-501-0163~~)) 182-501-0163;

(f) Approved, when required, in accordance with WAC ((~~388-501-0165~~)) 182-501-0165;

(g) Furnished by a provider according to chapter ((~~388-502~~)) 182-502 WAC; and

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

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

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

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

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

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

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

(b) Otherwise allowed under ((~~chapter 388-500 WAC~~)) specific agency program rules.

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

(9) **Covered healthcare services.**

(a) Covered healthcare services are either:

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

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

(b) The ((~~department~~)) agency or the agency's designee may limit the scope, amount, duration, and/or frequency of covered healthcare services. Limitation extensions are authorized according to WAC ((~~388-501-0169~~)) 182-501-0169.

(10) **Noncovered healthcare services.**

(a) The ((~~department~~)) agency or the agency's designee does not pay for any healthcare service((~~:~~

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

~~(ii)~~)) listed as noncovered in WAC ((~~388-501-0070~~)) 182-501-0070 or in any other agency program rule. The ((~~department~~)) agency or the agency's designee evaluates a request for a noncovered healthcare service only if an exception to rule is requested according to the provisions in WAC ((~~388-501-0160~~)) 182-501-0160.

(b) When a noncovered healthcare service is recommended during the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam and then ordered by a provider, the ((~~department~~)) agency or the agency's designee evaluates the healthcare service according to the process in WAC ((~~388-501-0165~~)) 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC ((~~388-534-0100~~)) 182-534-0100 for EPSDT rules).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-501-0060 Healthcare coverage—((~~Scope of covered categories of service~~)) Program benefits packages—Scope of service categories. (((~~(1) This rule provides a list (see subsection (5)) of medical, dental, mental health, and substance abuse categories of service covered by the department under categorically needy (CN) medicaid, medically needy (MN) medicaid, Alien Emergency Medical (AEM), and medical care services (MCS) programs. MCS means the limited scope of care financed by state funds and provided to general assistance and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program clients.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~• The letter "E" means the service category is available only if it is necessary to treat the client's emergency medical condition and may require prior authorization from the department.~~

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

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

~~Service Categories~~	~~CN*~~	~~MN~~	~~MCS~~	~~AEM~~
~~(aa) School medical services~~	~~C~~	~~C~~	~~N~~	~~N~~
~~(bb) Substance abuse services~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(cc) Therapy - occupational/physical/speech~~	~~C~~	~~C~~	~~C~~	~~E~~
~~(dd) Vision care (exams/lenses)~~	~~C~~	~~C~~	~~C~~	~~E~~

~~*Clients enrolled in the State Children's Health Insurance Program and the Children's Health Program receive CN scope of medical care.~~)) (1) This rule provides a table that lists:

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

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

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

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

(a) Are determined, in accordance with WAC 182-501-0050 and 182-501-0055 when applicable.

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

(c) May require prior authorization (see WAC 182-501-0165), or expedited authorization when allowed by the agency or the agency's designee.

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

(4) The agency or the agency's designee does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the agency or the agency's designee, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the agency or the agency's designee as required under chapter 182-502 WAC;

(c) Are included in an agency or an agency's designee waiver program identified in chapter 388-515 WAC; or

(d) Are covered by a third-party payor (see WAC 182-501-0200), including medicare, if the third-party payor has not made a determination on the claim or has not been billed by the provider.

(5) Other programs:

(a) Early and periodic screening, diagnosis, and treatment (EPSDT) services are not addressed in the table. For EPSDT services, see chapter 182-534 WAC and WAC 182-501-0050(10).

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

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

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

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

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

(d) The letter **"N"** means a service category is not included for that program.

(e) Refer to WAC 182-501-0065 for a description of each service category and for the specific program WAC containing the limitations and restrictions to services.

Service Categories	CN[1] 20-	21+	MN 20-	21+	MCS DL
Adult day health	Y	Y	Y[2]	N	N
Ambulance (ground and air)	Y	Y	Y	Y	Y
Blood processing/administration	Y	Y	Y	Y	Y
Dental services	Y	N	Y	N	N
Detoxification	Y	Y	Y	Y	Y
Diagnostic services (lab and X ray)	Y	Y	Y	Y	Y
Healthcare professional services	Y	Y	Y	Y	Y
Hearing evaluations	Y	Y	Y	Y	Y
Hearing aids	Y	N	Y	N	N
Home health services	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y
Hospital services - Inpatient/outpatient	Y	Y	Y	Y	Y
Intermediate care facility/services for mentally retarded	Y	Y	Y	Y	Y
Maternity care and delivery services	Y	Y	Y	Y	N

Service Categories	CN[1] 20-	21+	MN 20-	21+	MCS DL
Medical equipment, durable (DME)	Y	Y	Y	Y	Y
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y
Medical nutrition services	Y	Y	Y	Y	Y
Mental health services:					
• Inpatient care	Y	Y	Y	Y	Y
• Outpatient community mental health services	Y	Y	Y	Y	Y[3]
• Psychiatrist visits	Y	Y	Y	Y	Y[4]
• Medication management	Y	Y	Y	Y	Y
Nursing facility services	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y
Out-of-state services	Y	Y	Y	Y	N
Oxygen/respiratory services	Y	Y	Y	Y	Y
Personal care services	Y	Y	N	N	N
Prescription drugs	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	N
Prosthetic/orthotic devices	Y	Y	Y	Y	Y
Psychological evaluation[5]	Y	Y	Y	Y	N
Reproductive health services (includes family planning and TAKE CHARGE)	Y	Y	Y	Y	Y
Substance abuse services	Y	Y	Y	Y	Y
Therapy - Occupational, physical and speech	Y	Y	Y	Y	Y
Vision care - Exams, refractions, and fittings	Y	Y	Y	Y	Y
Vision - Frames and lenses	Y	N	Y	N	N

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

[2] Restricted to 18-20 year olds.

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

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

[5] Only two allowed per lifetime.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-501-0065 Healthcare coverage—Description of ((~~covered~~)) categories of service. This rule provides a brief description of the medical, dental, mental health, and substance abuse service categories listed in the table in WAC ((~~388-501-0060~~)) 182-501-0060. The description of services under each category is not intended to be all inclusive.

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

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

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

(b) **Ambulance**—Emergency medical transportation and ambulance transportation for nonemergency medical needs. ((~~[WAC 388-546-0001 through 388-546-4000]~~)) (WAC 182-546-0001 through 182-546-4000)

(c) **Blood processing/administration**—Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. ((~~[WAC 388-550-1400 and 388-550-1500]~~)) (WAC 182-550-1400 and 182-550-1500)

(d) **Dental services**—Diagnosis and treatment of dental problems including emergency treatment and preventive care. ((~~[Chapters 388-535 and 388-535A WAC]~~)) (Chapters 182-535 and 182-535A WAC)

(e) **Detoxification**—Inpatient treatment performed by a certified detoxification center or in an inpatient hospital setting. ((~~[~~))(WAC 388-800-0020 through 388-800-0035; and ((~~388-550-1100]~~)) 182-550-1100)

(f) **Diagnostic services**—Clinical testing and imaging services. ((~~[WAC 388-531-0100; 388-550-1400 and 388-550-1500]~~)) (WAC 182-531-0100; 182-550-1400 and 182-550-1500)

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

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

~~(i)~~)) (Chapter 182-531 WAC)

(h) **Hearing ((~~care~~)) evaluations**—Audiology; diagnostic evaluations; hearing exams and testing((~~; and hearing aids. [WAC 388-544-1200 and 388-544-1300; 388-545-700; and 388-531-0100]~~)) (WAC 182-531-0100 and 182-531-0375)

(i) **Hearing aids**—(chapter 182-547 WAC)

(j) **Home health services**—Intermittent, short-term skilled nursing care, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. ((~~[WAC 388-551-2000 through 388-551-2220]~~)) (WAC 182-551-2000 through 182-551-2220)

(k) **Hospice services**—Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. ((~~[WAC 388-551-1210 through 388-551-1850]~~)) (WAC 182-551-1210 through 182-551-1850)

(l) **Hospital services—Inpatient/outpatient**—Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. ((~~[Chapter 388-550 WAC]~~)) (Chapter 182-550 WAC)

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

(n) **Maternity care and delivery services**—Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, family planning services and community health worker visits. ((~~[WAC 388-533-0330]~~)) (WAC 182-533-0300)

(o) **Medical equipment, durable (DME)**—Wheelchairs, hospital beds, respiratory equipment; prosthetic and orthotic devices; casts, splints, crutches, trusses, and braces. ((~~[WAC 388-543-1100]~~)) (Chapter 182-543 WAC)

(p) **Medical equipment, nondurable (MSE)**—Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, ((~~transcutaneous electrical nerve stimulators (TENS) supplies,~~)) and urological supplies. ((~~[WAC 388-543-2800]~~)) (Chapter 182-543 WAC)

(q) **Medical nutrition services**—Enteral and parenteral nutrition, including supplies. ((~~[Chapters 388-553 and 388-554 WAC]~~)) (Chapters 182-553 and 182-554 WAC)

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

(i) Inpatient care - Voluntary and involuntary admissions for psychiatric services. (WAC 182-550-2600)

(ii) Outpatient (community mental health) services - Nonemergency, nonurgent counseling. (WAC 182-531-1400, 388-865-0215, and 388-865-0230)

(iii) Psychiatric visits. (WAC 182-531-1400 and 388-865-0230)

(iv) Medication management. (WAC 182-531-1400)

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

(t) **Organ transplants**—Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. ((~~[WAC 388-550-1900 and 388-550-2000, and 388-556-0400]~~)) (WAC 182-550-1900 and 182-556-0400)

(u) **Out-of-state services**—((~~Emergency services; prior authorized care. Services provided in bordering cities are treated as if they were provided in state. [WAC 388-501-0175 and 388-501-0180; 388-531-1100; and 388-556-0500]~~)) See WAC 182-502-0120 for payment of services out-of-state.

(v) **Oxygen/respiratory services**—Oxygen, oxygen equipment and supplies; oxygen and respiratory therapy, equipment, and supplies. ((~~[Chapter 388-552 WAC]~~)) (Chapter 182-552 WAC)

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

(x) **Prescription drugs**—Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. ((~~[WAC 388-530-1100]~~)) (WAC 182-530-2000.) Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(y) **Private duty nursing**—Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. ((~~[WAC 388-551-3000.]~~)) (WAC 182-551-3000.) For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(z) **Prosthetic/orthotic devices**—Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. ((~~[WAC 388-543-1100]~~)) (WAC 182-543-1100)

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

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

(bb) **Reproductive health services**—Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. (WAC 182-532-530)

(cc) **Substance abuse services**—Chemical dependency assessment, case management services, and treatment services. ((~~[WAC 388-533-0701 through 388-533-0730; 388-556-0100 and 388-556-0400~~)) (WAC 182-533-0701 through 182-533-0730; 182-556-0100 and 182-556-0400; and 388-800-0020((~~]~~)))

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

~~(dd)~~)) (Chapter 182-545 WAC)

(ee) **Vision care**—Eye exams, refractions, ((~~frames, lenses,~~)) fittings, visual field testing, vision therapy, ocular prosthetics, and surgery. ((~~[WAC 388-544-0250 through 388-544-0550]~~)) (WAC 182-531-1000)

(ff) **Vision hardware**—Frames and lenses. (Chapter 182-544 WAC)

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-501-0070 Healthcare coverage—Noncovered services. (1) The ((~~department~~)) agency or the agency's designee does not pay for any healthcare service not listed or referred to as a covered healthcare service under the medical programs described in WAC ((~~388-501-0060~~)) 182-501-0060, regardless of medical necessity. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. Circumstances in which clients are responsible for payment of healthcare services are described in WAC ((~~388-502-0160~~)) 182-502-0160.

(2) This section does not apply to healthcare services provided as a result of the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter ((~~388-534~~)) 182-534 WAC.

(3) The ((~~department~~)) agency or the agency's designee does not pay for any ancillary healthcare service(s) provided in association with a noncovered healthcare service.

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

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

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

(c) Chiropractic care for adults;

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

(e) Discography;

(f) Ear or other body piercing;

(g) Face lifts or other facial cosmetic enhancements;

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

(i) Artificial insemination;

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

(iii) In vitro fertilization;

(iv) Penile implants;

(v) Reversal of sterilization; and

(vi) Sex therapy.

(i) Gender reassignment surgery and any surgery related to trans-sexualism, gender identity disorders, and body dysmorphism, and related healthcare services or procedures, including construction of internal or external genitalia, breast augmentation, or mammoplasty;

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

(k) Marital counseling;

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

(m) Nonmedical equipment;

(n) Penile implants;

(o) Prosthetic testicles;

(p) Psychiatric sleep therapy;

(q) Subcutaneous injection filling;

(r) Tattoo removal;

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

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

(u) Vehicle purchase - new or used vehicle.

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

(a) Ambulance transportation and nonemergent transportation as described in chapter ((~~388-546~~)) 182-546 WAC;

(b) Dental services for clients twenty years of age and younger as described in chapter ((~~388-535~~)) 182-535 WAC;

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

~~(d)~~)) Durable medical equipment as described in chapter ((~~388-543~~)) 182-543 WAC;

(((~~(e)~~))) (d) Hearing ((~~care services~~)) aids for clients twenty years of age and younger as described in chapter ((~~388-547~~)) 182-547 WAC;

(((~~(f)~~))) (e) Home health services as described in WAC ((~~388-551-2130~~)) 182-551-2130;

(((~~(g)~~))) (f) Hospital services as described in WAC ((~~388-550-1600~~)) 182-550-1600;

(((~~(h) Physician-related~~))) (g) Healthcare professional services as described in WAC ((~~388-531-0150~~)) 182-531-0150;

(((~~(i)~~))) (h) Prescription drugs as described in chapter ((~~388-530~~)) 182-530 WAC; ((~~and~~

~~(j)~~))) (i) Vision care ((~~services~~)) hardware for clients twenty years of age and younger as described in chapter ((~~388-544~~)) 182-544 WAC; and

(j) Vision care exams as described in WAC 182-531-1000.

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

(a) A statement of the action the ((~~department~~)) agency or the agency's designee intends to take;

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

(c) Sufficient detail to enable the recipient to:

(i) Learn why the ((~~department's~~)) agency's or the agency designee's action was taken; and

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

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

(e) The following information:

(i) Administrative hearing rights;

(ii) Instructions on how to request the hearing;

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

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

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

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

(7) A client can request an exception to rule (ETR) as described in WAC ((~~388-501-0160~~)) 182-501-0160.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-502-0160 Billing a client. (1) The purpose of this section is to specify the limited circumstances in which:

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

(b) Providers (as defined in WAC ((~~388-500-0005~~)) 182-500-0085) have the authority to bill fee-for-service or managed care clients for medical assistance services furnished to those clients.

(2) The provider is responsible for:

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

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

(c) Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC ((~~388-501-0050 (4)(a) and 388-501-0065~~)) 182-501-0050 (4)(a) and 182-501-0065);

(d) Informing the client of those limitations;

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

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

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

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

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

(a) Any services for which the provider failed to satisfy the conditions of payment described in ((~~department's~~)) the agency's rules, the ((~~department's~~)) agency's fee-for-service billing instructions, and the requirements for billing the ((~~department-contracted~~)) agency-contracted MCO in which the client is enrolled.

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

(c) A covered service when the ((~~department~~)) agency or the agency's designee denies an authorization request for the service because the required information was not received from the provider or the prescriber under WAC ((~~388-501-0165~~)) 182-501-0165 (7)(c)(i).

(5) If the requirements of this section are satisfied, then a provider may bill a fee-for-service or a managed care client for a covered service, defined in WAC ((~~388-501-0050(9)~~)) 182-501-0050(9), or a noncovered service, defined in WAC ((~~388-501-0050(10) and 388-501-0070~~)) 182-501-0050(10) and 182-501-0070. The client and provider must sign and date the ((~~DSHS~~)) form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished.

((~~DSHS~~)) Form 13-879, including translated versions, is available to download at ((~~http://www1.dshs.wa.gov/msa/forms/eforms.html~~)) http://hrsa.dshs.wa.gov/mpforms.shtml. The requirements for this subsection are as follows:

(a) The agreement must:

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

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

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

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

(v) Specify what items or services are included in this amount (such as pre-operative care and postoperative care). See WAC ((~~388-501-0070(3)~~)) 182-501-0070(3) for payment of ancillary services for a noncovered service;

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

(vii) Specify that the client may request an exception to rule (ETR) in accordance with WAC ((~~388-501-0160~~)) 182-501-0160 when the ((~~department~~)) agency or the agency's designee denies a request for a noncovered service and that the client may choose not to do so;

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

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

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

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

(i) Not covered by the ((~~department~~)) agency or the client's ((~~department-contracted~~)) agency-contracted MCO and the ETR process as described in WAC ((~~388-501-0160~~)) 182-501-0160 has been exhausted and the service(s) is denied;

(ii) Not covered by the ((~~department~~)) agency or the client's ((~~department-contracted~~)) agency-contracted MCO and the client has been informed of his or her right to an ETR and has chosen not to pursue an ETR as described in WAC ((~~388-501-0160~~)) 182-501-0160;

(iii) Covered by the ((~~department~~)) agency or the client's ((~~department-contracted~~)) agency-contracted MCO, requires authorization, and the provider completes all the necessary requirements; however the ((~~department~~)) agency or the agency's designee denied the service as not medically necessary (this includes services denied as a limitation extension under WAC ((~~388-501-0169~~)) 182-501-0169); or

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

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

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

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

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

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

(i) Was reimbursed for the service directly by a third party (see WAC ((~~388-501-0200~~)) 182-501-0200); or

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

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

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

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

(c) The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the ((~~department~~)) agency or the agency's designee). See subsection (7) of this section for billing a medically needy client for spenddown liability;

(d) The client is under the ((~~department's~~)) agency's or ((~~a department-contracted~~)) an agency-contracted MCO's patient review and coordination (PRC) program (WAC ((~~388-501-0135~~)) 182-501-0135) and receives nonemergency services from providers or healthcare facilities other

than those to whom the client is assigned or referred under the PRC program;

(e) The client is a dual-eligible client with medicare Part D coverage or similar creditable prescription drug coverage and the conditions of WAC ((~~388-530-7700~~)) 182-530-7700 (2)(a)(iii) are met;

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

(g) The services were noncovered ambulance services (see WAC ((~~388-546-0250(2)~~)) 182-546-0250(2));

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

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

(j) The service is within a service category excluded from the client's benefits package. See WAC 182-501-0060.

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

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

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

(b) The client receives a delayed certification for medical assistance as defined in WAC ((~~388-500-0005~~)) 182-500-0025; or

(c) The client receives a certification for medical assistance for a retroactive period according to 42 CFR § 435.914 (a) and defined in WAC ((~~388-500-0005~~)) 182-500-0095.

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

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

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, ((~~cancelled~~)) canceled, or late appointments;

(c) Shipping and/or postage charges;

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

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

WSR 12-02-017
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed December 27, 2011, 11:45 a.m., effective December 27, 2011, 11:45 a.m.]

Effective Date of Rule: Immediately.

Purpose: Under the 2011-13 omnibus operating budget, the department must establish certification fees at an amount adequate to reimburse costs for its certification and regulation activities for approved chemical dependency treatment programs.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-805-080 and 388-805-090; and amending WAC 388-805-085 and 388-805-100.

Statutory Authority for Adoption: RCW 43.135.055 and 70.96A.090.

Other Authority: 2011-13 omnibus operating budget (2ESHB 1087).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with section 208 of 2ESHB 1087, which requires the department to increase fees for the review and approval of treatment programs in fiscal years 2012 and 2013 as necessary to support the costs of the regulatory program. Providers with proof of accreditation for programs will have fees that reflect a lower cost of certifying them. The law directs the increased fees to be implemented in fiscal years 2012 and 2013 as necessary to support the costs of the regulatory program.

This emergency filing replaces the emergency rule filed as WSR 11-18-038 on August 31, 2011. The CR-101 for the permanent rule was filed as WSR 11-18-073 on September 6, 201 [2011]. The CR-102 is expected to be filed December 21, 2011, with the public hearing to be held January 24, 2012.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 2.

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 1, Repealed 2.

Date Adopted: December 15, 2011.

Katherine I. Vasquez

Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-11-096, filed 5/17/06, effective 6/17/06)

WAC 388-805-085 ((~~What are the fees for agency certification?~~)) What are the fee requirements for chemical dependency treatment programs? (1) ((~~Application fees:~~))

(((~~(a) New agency~~))	((~~$500~~))
(((~~(b) Branch agency~~))	((~~$500~~))
(((~~(c) Application for adding one or more services~~))	((~~$200~~))
(((~~(d) Change in ownership~~))	((~~$500~~))

(((~~(2) Initial and annual certification fees:~~)))

(((~~(a) For detoxification and residential services:~~))	((~~$26 per licensed bed~~))
(((~~(b) For nonresidential services:~~))	
(((~~(i) Large size agencies: 3,000 or more patients served per year~~))	((~~$1,125 per year~~))
(((~~(ii) Medium size agencies: 1,000-2,999 patients served per year~~))	((~~$750 per year~~))
(((~~(iii) Small size agencies: 0-999 patients served per year~~))	((~~$375 per year~~))
(((~~(c) For agencies certified through deeming per WAC 388-805-115~~))	((~~$200 per year~~))

(((~~(3) Each year providers must complete a declaration form provided by the department indicating the number of patients served annually, the provider's national accreditation status, and other information necessary for establishing fees and updating certification information~~)) The department charges the following fees for approved chemical dependency treatment programs:

Application Fees for Agency Certification for Approved Chemical Dependency Treatment Programs

New agency application	$1,000
Branch agency application	$500
Application to add one or more services	$200
Application to change ownership	$500

Initial and Annual Certification Fees for Detoxification, Residential, and Nonresidential Services

Detoxification and residential services	$100 per licensed bed, per year, for agencies not renewing certification through deeming
	$50 per licensed bed, per year, for agencies renewing certification through deeming per WAC 388-805-115
Nonresidential services	$750 per year for agencies not renewing certification through deeming
	$200 per year for agencies certified through deeming per WAC 388-805-115

Complaint/Incident Investigation Fees

All agencies	$1,000 per substantiated complaint/incident investigation

(2) Agency providers must pay fees:

(a) Within thirty days of receiving an invoice from the department.

(b) By check, draft, or money order made payable to the department of social and health services.

(3) The department:

(a) May refund one-half of the application fee if an application is withdrawn before certification or denial.

(b) Will not refund fees when certification is denied, revoked, or suspended.

(4) Agency providers must annually complete a declaration form provided by the department to indicate information necessary for establishing fees and updating certification

information. Required information includes, but is not limited to:

(a) The number of licensed detoxification and residential beds; and

(b) The agency provider's national accreditation status.

AMENDATORY SECTION (Amending WSR 08-24-083, filed 12/1/08, effective 1/1/09)

WAC 388-805-100 What do I need to do to maintain agency certification? A service provider's continued certification and renewal is contingent upon:

(1) Completion of an annual declaration of certification.

(2) Payment of certification fees((~~, if applicable~~)).

(3) Providing the essential requirements for chemical dependency treatment, including the following elements:

(a) Treatment process:

(i) Assessments, as described in WAC 388-805-310;

(ii) Treatment planning, as described in WAC 388-805-315 (2)(a) and 388-805-325(11);

(iii) Documenting patient progress, as described in WAC 388-805-315 (1)(b) and 388-805-325(13);

(iv) Treatment plan reviews and updates, as described in WAC 388-805-315 (2)(a), 388-805-325(11) and 388-805-325 (13)(c);

(v) Patient compliance reports, as described in WAC 388-805-315 (4)(b), 388-805-325(17), and 388-805-330;

(vi) Continuing care, transfer summary and discharge planning, as described in WAC 388-805-315 (2)(c) and (d), (6)(a) and (b), and (7)(a), and 388-805-325 (18) and (19); and

(vii) Conducting individual and group counseling, as described in WAC 388-805-315 (2)(b) and 388-805-325(13).

(b) Staffing: Provide sufficient qualified personnel for the care of patients as described in WAC 388-805-140(5) and 388-805-145(5);

(c) Facility:

(i) Provide sufficient facilities, equipment, and supplies for the care and safety of patients as described in WAC 388-805-140 (5) and (6);

(ii) If a residential provider, be licensed by the department of health as described by WAC 388-805-015 (1)(b).

(4) Findings during periodic on-site surveys and complaint investigations to determine the provider's compliance with this chapter. During on-site surveys and complaint investigations, provider representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including patient clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with patients and staff members.

(5) The provider must post the notice of a scheduled department on-site survey in a conspicuous place accessible to patients and staff.

(6) The provider must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-805-080	What are the fee requirements for certification?
WAC 388-805-090	May certification fees be waived?

WSR 12-02-018
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed December 27, 2011, 12:04 p.m., effective December 27, 2011, 12:04 p.m.]

Effective Date of Rule: Immediately.

Purpose: Under the 2011-13 omnibus operating budget, the department must establish licensing and certification fees at an amount adequate to reimburse costs for its certification and regulation activities for approved mental health treatment programs.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-865-0474 and 388-865-0516.

Statutory Authority for Adoption: RCW 43.20B.110, 43.135.055, and 71.24.035.

Other Authority: 2011-13 omnibus operating budget (2ESHB 1087).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with section 204 of 2ESHB 1087, which requires the department to increase fees for the review and approval of treatment programs in fiscal years 2012 and 2013 as necessary to support the costs of the regulatory program. Providers with proof of accreditation for programs will have fees that reflect the lower cost of licensing than for other organizations which are not accredited. The law directs the increased fees to be implemented in fiscal years 2012 and 2013 as necessary to support the costs of the regulatory program. This emergency filing replaces the emergency rule filed as WSR 11-18-040 on August 31, 2011. The CR-101 for the permanent rule was filed as WSR 11-18-074 on September 6, 2011. The department plans on filing the CR-102 on December 21, 2011, with the public hearing to be held January 24, 2012.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 2.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 0, Repealed 2.

Date Adopted: December 15, 2011.

Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-865-0103 Fee requirements for mental health treatment programs. (1) The department charges the following fees to reimburse costs for its licensing and certification activities for approved mental health treatment programs:

New Agency Licensing Application Fee for Approved Mental Health Treatment Programs	
Licensing application fee for residential and nonresidential services—New agencies	$1000
Agencies not Certified through Deeming: Residential Services—Initial and Annual Certification Fees	
Evaluation and treatment (E&T) residential bed fees	$90 initial certification fee, per licensed bed $90 annual certification fee, per licensed bed
Agencies not Licensed through Deeming: Nonresidential Services—Initial and Annual Licensing Fees	
Annual service hours provided:	Initial and annual licensing fees:
0 - 3,999	$728
4,000 - 14,999	$1,055
15,000 - 29,999	$1,405
30,000 - 49,000	$2,105
50,000 or more	$2,575
Deemed agencies: Residential and Nonresidential Services—Renewal Licensing Fees	
Deemed agencies licensed by DBHR	$500 licensing fee
Complaint/Incident Investigation Fee	
All residential and nonresidential agencies	$1,000 per substantiated complaint/incident investigation

(2) Initial and annual licensing/certification fees identified in the table in subsection (1) of this section must:

(a) Be sent with an initial application or with an annual license/certification renewal.

(b) Cover a minimum of one year.

(c) Be made payable to the division of behavioral health and recovery by check, electronic fund transfer, or money order.

(3) Failure to pay fees when due will result in suspension or denial of the license/certification.

(4) The department:

(a) May refund one-half of the fees submitted with an application upon the receipt of the applicant if the application is withdrawn before the department issues the license.

(b) Will not refund fees when a license or certificate is denied, revoked, or suspended.

(c) Requires a new license and payment of fees for a change in agency ownership.

(5) Agencies providing nonresidential services must report the number of annual service hours provided based on the division of behavioral health and recovery's (DBHR's) current published "Service Encounter Reporting Instructions for RSNs" and the "Consumer Information System (CIS) Data Dictionary for RSNs." These publications are available at the DBHR website at: http://www.dshs.wa.gov/dbhr/mhpublications.shtml.

(a) Existing licensed agencies must compute the annual service hours based on the most recent state fiscal year.

(b) Newly licensed agencies must compute the annual service hours by projecting the service hours for the first twelve months of operation.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-865-0474	Fees for community support service provider licensure.
WAC 388-865-0516	Certification fees.

WSR 12-02-020
EMERGENCY RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed December 27, 2011, 3:14 p.m., effective January 1, 2012]

Effective Date of Rule: January 1, 2012.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: RCW 50.22.010 (2)(c) and (3)(c) provide that the determination of an "on" indicator and of a "high unemployment period" are based on a "look back" at the unemployment rates for the three preceding calendar years. This provision expires on December 31, 2011, or on such subsequent date as provided by the department by rule, consistent with the purposes of the statute. The President has signed the Temporary Payroll Tax Cut Continuation Act of 2011 which extends the "three year look back" provision until February 29, 2012.

Purpose: Consistent with federal law, the rule extends until February 29, 2012, the "three year look back" calculation for determining an "on" indicator under RCW 50.22.010 (2)(c) and determining a "high unemployment period" under RCW 50.22.010 (3)(c).

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, and 50.22.010.

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

Reasons for this Finding: Determining the extended benefit period based on a three year, rather than a two year, "look back" means that the "off" indicator will not take effect in January 2012 as had been anticipated and extended benefits will be available to unemployed individuals beyond that date.

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

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

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

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

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

Date Adopted: December 27, 2011.

Joel Sacks
Deputy Commissioner

NEW SECTION

WAC 192-240-900 How will the extended benefit period be determined? As provided in the federal Temporary Payroll Tax Cut Continuation Act of 2011, the use of unemployment rates for the preceding three calendar years is extended until February 29, 2012, for the following:

(1) The determination of an "on" indicator as provided in RCW 50.22.010 (2)(c); and

(2) The determination of a "high unemployment period" as provided in RCW 50.22.010 (3)(c).

WSR 12-02-022
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-322—Filed December 28, 2011, 9:26 a.m., effective January 2, 2012]

Effective Date of Rule: January 2, 2012.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900U; and amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: The 2011-12 upper Columbia River steelhead run is less than in recent years and has a relatively high proportion of natural origin steelhead. The higher proportion of natural origin steelhead coupled with steady angler effort has increased the number of natural origin steelhead encounters and catch and release mortality. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: December 28, 2012.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900X Exceptions to statewide rules. (1) Notwithstanding the provisions of WAC 232-28-619, effective January 2, 2012, until further notice, special daily

limit of two hatchery steelhead, 20-inch minimum size. Release all steelhead with one or more round 1/4-inch diameter holes punched in the caudal (tail) fin. Mandatory retention in effect. Whitefish anglers must follow selective gear rules in areas open to steelhead fishing, no bait is allowed.

(a) Okanogan River from the mouth upstream to Hwy 97 Bridge in Oroville: Open until further notice. Night closure and selective gear rules apply.

(b) Similkameen River from its mouth to 400 feet below Enloe Dam: Open until further notice. Night closure and selective gear rules apply.

(2) Notwithstanding the provisions of WAC 232-28-619, effective January 2, 2012, until further notice it is unlawful to fish for whitefish in the following waters:

(a) Wenatchee River - From the mouth to the Hwy 2 bridge at Leavenworth.

(b) Entiat River - upstream from the Alternate Highway 97 Bridge, near the mouth of the Entiat River to Entiat Falls.

(c) Methow River - from Gold Creek to the falls above Brush Creek.

REPEALER

The following section of the Washington Administrative Code is repealed effective January 2, 2012:

WAC 232-28-61900U	Exceptions to statewide rules—Columbia, Entiat, Methow, Okanogan, Similkameen and Wenatchee rivers. (11-258)

WSR 12-02-033
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 29, 2011, 1:06 p.m., effective December 31, 2011]

Effective Date of Rule: December 31, 2011.

Purpose: Upon order of the governor, the health care authority (HCA) was required to reduce its budget expenditures for fiscal year 2011 by 6.3 percent. This cost-saving measure was implemented as part of this mandated reduction and to bring HCA's payment methodology for qualified medicare beneficiary (QMB) clients into alignment with the payment formula established in WAC 182-502-0110 for medicare/medicaid dual-eligible QMB clients.

Citation of Existing Rules Affected by this Order: Amending WAC 388-517-0320.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: 42 U.S.C. § 1396a (n)(2).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required HCA and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3 percent. This emergency rule is necessary while HCA completes the permanent rule-making process initiated by the CR-101 filed under WSR 11-09-056. HCA filed the CR-102 proposal under WSR 12-01-127 and will hold a public hearing on January 24, 2012.

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: December 29, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-15-032, filed 7/12/07, effective 8/12/07)

WAC 388-517-0320 Medicare savings and state-funded medicare buy-in programs cover some client costs. (1) For qualified medicare beneficiary (QMB) clients, the ((~~department~~)) agency pays((~~:~~

~~(a) Medicare Part A premiums (if any);~~

~~(b) Medicare Part B premiums;~~

~~(c) Coinsurance, deductibles, and copayments for medicare Part A, Part B, and medicare advantage Part C with the following conditions:~~

~~(i) Only the Part A and Part B deductible, coinsurance, and copayments up to the medicare or medicaid allowed amount, whichever is less (WAC 388-502-0110), if the service is covered by medicare and medicaid.~~

~~(ii) Only the deductible, coinsurance, and copayments up to the medicare allowed amount if the service is covered only by medicare.~~

~~(d) Copayments for QMB-eligible clients enrolled in medicare advantage Part C up to the medicare or medicaid allowed amount whichever is less (WAC 388-502-0110).~~

~~(c) QMB Part A and/or Part B premiums the first of the month following the month the QMB eligibility is determined~~)) medicare Part A premiums (if any) and medicare Part B premiums the first of the month following the month the QMB eligibility is determined. The agency pays, in accordance with WAC 182-502-0110, medicare coinsurance, deductibles, and copayments for medicare Part A, Part B and medicare advantage Part C.

(2) For specified low-income medicare beneficiary (SLMB) clients, the ((~~department~~)) agency pays medicare Part B premiums effective up to three months prior to the certification period if eligible for those months. No other payments are made for SLMBs. For clients eligible for both SLMB and medicaid, the agency pays medicare Part B premiums and other medical costs in accordance with WAC 182-502-0110.

(3) For qualified individual (QI-1) clients, the ((~~department~~)) agency pays medicare Part B premiums effective up to three months prior to the certification period if eligible for those months unless:

(a) The client receives medicaid categorically needy (CN) or medically needy (MN) benefits; and/or

(b) The ((~~department's~~)) agency's annual federal funding allotment is spent. The ((~~department~~)) agency resumes QI-1 benefit payments the beginning of the next calendar year.

(4) For qualified disabled working individual (QDWI) clients, the ((~~department~~)) agency pays medicare Part A premiums effective up to three months prior to the certification period if eligible for those months. The ((~~department~~)) agency stops paying medicare Part A premiums if the client begins to receive CN or MN medicaid.

(5) For state-funded medicare buy-in program clients, the ((~~department~~)) agency pays((~~:~~

~~(a) Medicare Part B premiums; and~~

~~(b) Only the Part A and B co-insurance, deductibles, and copayments up to the medicare or medicaid allowed amount, whichever is less (WAC 388-502-0110), if the service is covered by medicare and medicaid.~~

~~(6) For the dual-eligible client, (a client receiving both medicare and CN or MN medical coverage) the department pays as follows:~~

~~(a) If the service is covered by medicare and medicaid, medicaid pays only the deductible, and coinsurance up to the medicare or medicaid allowed amount, whichever is less (WAC 388-502-0110); and~~

~~(b) Copayments for medicare advantage Part C up to the medicare or medicaid allowed copayment amount, whichever is less (WAC 388-502-0110);~~

~~(c) If no medicaid rate exists, the department will deny payment unless the client is also QMB then refer to section (1) above~~)), in accordance with WAC 182-502-0110, medicare Part B premiums. Cost sharing for medicare deductibles, copayments and coinsurance is paid by the categorically needy (CN) or medically needy (MN) medicaid program.

WSR 12-02-044

EMERGENCY RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Aging and Disability Services Administration)

[Filed December 30, 2011, 10:24 a.m., effective December 30, 2011, 10:24 a.m.]

Effective Date of Rule: Immediately.

Purpose: The department is amending WAC 388-106-0010 Definitions and 388-106-0210 Medicaid personal care (MPC) eligibility, to include the age guidelines.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0210 and 388-106-0010.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

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

Reasons for this Finding: The department revised its assessment process to allocate for personal care services for children on a more individualized basis. The changes to WAC 388-106-0010 and 388-106-0210 are necessary to comport with previously adopted emergency amendments to WAC 388-106-0130 under WSR 11-23-082 filed on November 16, 2011. The emergency rule is necessary in order to comply with the state law following the Supreme Court decision in *Samantha A. v. DSHS*.

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 2, 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 2, Repealed 0.

Date Adopted: December 28, 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 12-03 issue of the Register.

WSR 12-02-045
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Financial Services Administration)
[Filed December 30, 2011, 11:26 a.m., effective January 1, 2012]

Effective Date of Rule: January 1, 2012.

Purpose: The department is amending sections of chapter 388-06 WAC to implement Initiative 1163 passed by the voters on November 8, 2011. Initiative 1163 changes the effective date for long-term care fingerprint requirements from January 1, 2014, to January 1, 2012, and delays fingerprint requirements for community residential service providers until January 1, 2016.

Citation of Existing Rules Affected by this Order: Amending WAC 388-06-0020, 388-06-0110, 388-06-0150, 388-06-0525, and 388-06-0540.

Statutory Authority for Adoption: RCW 43.43.832, chapter 74.39A RCW.

Other Authority: Washington Initiative 1163.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: See above.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 5, Repealed 0.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: December 20, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-16-083, filed 7/30/10, effective 8/30/10)

WAC 388-06-0020 What definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter? The following definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter:

"Authorized" or **"authorization"** means not disqualified by the department to have unsupervised access to children and individuals with a developmental disability. This includes persons who are certified, contracted, allowed to receive payments from department funded programs, or volunteer.

"CA" means children's administration, department of social and health services. Children's administration is the cluster of programs within DSHS responsible for the provision of licensing of foster homes, group facilities/programs and child-placing agencies, child protective services, child welfare services, and other services to children and their families.

"Certification" means:

(1) Department approval of a person, home, or facility that does not legally need to be licensed, but wishes to have evidence that they met the minimum licensing requirements.

(2) Department licensing of a child-placing agency to certify and supervise foster home and group care programs.

"Children" and **"youth"** are used interchangeably in this chapter and refer to individuals who are under parental or department care including:

(1) Individuals under eighteen years old; or

(2) Foster children up to twenty-one years of age and enrolled in high school or a vocational school program; or

(3) Developmentally disabled individuals up to twenty-one years of age for whom there are no issues of child abuse and neglect; or

(4) JRA youth up to twenty-one years of age and who are under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Civil adjudication proceeding" is a judicial or administrative adjudicative proceeding that results in a finding of, or upholds an agency finding of, domestic violence, abuse, sexual abuse, neglect, abandonment, violation of a professional licensing standard regarding a child or vulnerable adult, or exploitation or financial exploitation of a child or vulnerable adult under any provision of law, including but not limited to chapter 13.34, 26.44 or 74.34 RCW, or rules adopted under chapters 18.51 and 74.42 RCW. "Civil adjudication proceeding" also includes judicial or administrative findings that become final due to the failure of the alleged perpetrator to timely exercise a legal right to administratively challenge such findings.

"Community residential service providers" include all division of developmental disabilities supported living providers with the exception of supported living providers who are also licensed as a boarding home or adult family home provider. Community residential service providers also include DDD companion homes, DDD alternative living and licensed residential homes for children.

"DCFS" means division of children and family services and is a division within children's administration that provides child welfare, child protective services, and support services to children in need of protection and their families.

"DDD" means the division of developmental disabilities, department of social and health services (DSHS).

"DLR" means the division of licensed resources that is a division within children's administration, the department of social and health services.

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

"I" and **"you"** refers to anyone who has unsupervised access to children or to persons with developmental disabilities in a home, facility, or program. This includes, but is not limited to, persons seeking employment, a volunteer opportu-

nity, an internship, a contract, certification, or a license for a home or facility.

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"Licensor" means an employee of DLR or of a child placing agency licensed or certified under chapter 74.15 RCW to approve and monitor licenses for homes or facilities that offer care to children. Licenses require that the homes and facilities meet the department's health and safety standards.

"Individual provider" as defined in RCW 74.39A.240 means a person, including a personal aide, who has contracted with the department to provide personal care or respite care services to functionally disabled persons under the medicaid personal care, community options program entry system, chore services program, or respite care program, or to provide respite care or residential services and supports to persons with developmental disabilities under chapter 71A.12 RCW, or to provide respite care as defined in RCW 74.13.270.

"Individuals with a developmental disability" means individuals who meet eligibility requirements in Title 71A RCW. A developmental disability is any of the following: Intellectual disability, cerebral palsy, epilepsy, autism, or another neurological condition described in chapter 388-823 WAC; originates before the age of eighteen years; is expected to continue indefinitely; and constitutes a substantial limitation to the individual.

"Spousal abuse" includes any crime of domestic violence as defined in RCW 10.99.020 when committed against a spouse, former spouse, person with whom the perpetrator has a child regardless of whether the parents have been married or lived together at any time, or an adult with whom the perpetrator is presently residing or has resided in the past.

"Unsupervised" means not in the presence of:

(1) The licensee, another employee or volunteer from the same business or organization as the applicant who has not been disqualified by the background check.

(2) Any relative or guardian of the child or developmentally disabled individual or vulnerable adult to whom the applicant has access during the course of his or her employment or involvement with the business or organization (RCW 43.43.080(9)).

"Unsupervised access" means that an individual will or may be left alone with a child or vulnerable adult (individual with developmental disability) at any time for any length of time.

"We" refers to the department, including licensors and social workers.

"WSP" refers to the Washington state patrol.

AMENDATORY SECTION (Amending WSR 10-16-083, filed 7/30/10, effective 8/30/10)

WAC 388-06-0110 Who must have background checks? (1) Per RCW 74.15.030, the department requires background checks on all providers who may have unsupervised access to children or individuals with a developmental disability. This includes licensed, certified or contracted providers, their current or prospective employees and prospective adoptive parents as defined in RCW 26.33.020.

(2) Per ((~~RCW 74.39A.055, the department requires state and federal background checks on all long-term care workers for the elderly or persons with disabilities hired or~~)) chapter 74.39A RCW long-term care workers, including individual providers, contracted after January 1, 2012 must be screened through a Washington state name and date of birth background check and a national fingerprint-based background check.

(a) This does not include long-term care workers qualified and contracted or hired on or before December 31, 2011. Background check renewals for individuals qualified and contracted or hired on or before December 31, 2011 will be conducted as follows:

(i) An individual who has continuously resided in Washington State for the past three years will be screened through a state name and date of birth check provided they do not experience a break in service or contract.

(ii) An individual who has resided in the state for less than three consecutive years shall be screened through a national fingerprint-based background check in addition to the state name and date of birth check.

(b) DDD community residential service providers will be screened as described in subsection (2)(a)(i) and (ii) of this section. Community residential service providers are not subject to the long-term care fingerprint requirement until January 2016.

(c) Parents are not exempt from the long-term care background check requirements.

(3) Per RCW 74.15.030, the department also requires background checks on other individuals who may have unsupervised access to children or to individuals with a developmental disability in department licensed or contracted homes, or facilities which provide care. The department requires background checks on the following people:

(a) A volunteer or intern with regular or unsupervised access to children;

(b) Any person who regularly has unsupervised access to a child or an individual with a developmental disability;

(c) A relative other than a parent who may be caring for a child;

(d) A person who is at least sixteen years old, is residing in a foster home, relatives home, or child care home and is not a foster child.

AMENDATORY SECTION (Amending WSR 10-16-083, filed 7/30/10, effective 8/30/10)

WAC 388-06-0150 What does the background check cover? (1) The department must review criminal convictions and pending charges based on identifying information provided by you. The background check may include but is not limited to the following information sources:

(a) Washington state patrol.

(b) Washington courts.

(c) Department of corrections.

(d) Department of health.

(e) Civil adjudication proceedings.

(f) Applicant's self-disclosure.

(g) Out-of-state law enforcement and court records.

(2) Except as required in WAC 388-06-0150 (4)(b) and (5), children's administration and division of developmental disabilities will conduct a fingerprint-based background check on any individual who has lived in Washington state for less than three years.

(3) Background checks conducted for children's administration also include:

(a) A review of child protective services case files information or other applicable information system.

(b) Administrative hearing decisions related to any DSHS license that has been revoked, suspended, or denied.

(4) In addition to the requirements in subsections (1) through (3) of this section, background checks conducted by children's administration for placement of a child in out-of-home care, including foster homes, adoptive homes, relative placements, and placement with other suitable persons under chapter 13.34 RCW, include the following for each person over eighteen years of age residing in the home:

(a) Child abuse and neglect registries in each state a person has lived in the five years prior to conducting the background check.

(b) Washington state patrol (WSP) and Federal Bureau of Investigation (FBI) fingerprint-based background checks regardless of how long you have resided in Washington.

(5) The division of developmental disabilities requires fingerprint-based background checks for ((~~all~~)):

(a) Long-term care workers as defined in ((~~RCW 74.39A.009(16)~~)) chapter 74.39A RCW hired or contracted on or after January 1, 2012 except community residential service providers. Community residential service providers are not subject to the long-term care fingerprint requirement until January 2016. These background checks must include a review of conviction records through the Washington state patrol, the Federal Bureau of Investigation, and the national sex offender registry.

(b) Providers who are subject to a background check who have resided in Washington State for less than three consecutive years.

AMENDATORY SECTION (Amending WSR 10-16-083, filed 7/30/10, effective 8/30/10)

WAC 388-06-0525 When are individuals eligible for the one hundred twenty-day provisional hire? (1) Individuals are eligible for the one hundred twenty-day provisional hire immediately. The signed background check application and fingerprinting process must be completed as required by the applicable DSHS program.

(2) Long-term care workers as defined in chapter 74.39A RCW are eligible for the one hundred twenty-day provisional hire pending the outcome of the fingerprint-based background check provided the individual is not disqualified as a result of the initial name and date of birth background check and provided a provisional hire is allowed by the applicable DSHS program rules and statutes.

AMENDATORY SECTION (Amending WSR 01-15-019, filed 7/10/01, effective 8/10/01)

WAC 388-06-0540 Are there instances when the one hundred twenty-day provisional hire is not available? With the exception of WAC 388-06-0525(2) the one hundred twenty-day provisional hire is not available to an agency, entity, or hiring individual requesting:

(1) An initial license;

(2) An initial contract; ((~~or~~))

(3) Approval as a family child day care home provider, foster parent or adoptive parent (see 42 U.S.C. Sec 671 (a)(20)); or

(4) Approval as an adult family home provider, boarding home licensee, administrator, staff or any long-term care worker employed in these long-term care facilities (see RCW 70.128.130(13) and RCW 18.20.125(4)).

WSR 12-02-049
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed December 30, 2011, 11:45 a.m., effective January 1, 2012]

Effective Date of Rule: January 1, 2012.

Purpose: The purpose of the new language in chapters 388-71 and 388-112 WAC is to implement and clarify the training requirements and the criminal history background check requirements as directed in chapter 74.39A RCW and to revise the implementation effective dates as directed by Initiative 1163. Chapter 74.39A WAC requires training for long-term care workers which includes seventy-five hours of entry-level training and also requires federal and state criminal history background checks for all long-term care workers. This law increases the basic training hour requirements for long-term care workers from thirty-two hours to seventy-five hours and increases their continuing education hour requirement from ten to twelve hours annually. Initiative 1163, enacted by the people in November 2011, requires implementation of these rules effective beginning January 7, 2012 (unless otherwise specified). These emergency rules are necessary in order to reflect the effective dates. Two additional changes were made based on two other law changes: A change was made to WAC 388-112-0075(3) to comply with section 206(16) of ESHB 1277 which requires that an adult family home has a qualified caregiver that is on-site whenever a resident is in the adult family home. A change was made to WAC 388-71-0517 to implement another state law, RCW 74.39A.326, which was enacted in 2009 as SHB 2361.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-71-05665, 388-71-05670, 388-71-05675, 388-71-05680, 388-71-05685, 388-71-05690, 388-71-05695, 388-71-05700, 388-71-05705, 388-71-05710, 388-71-05715, 388-71-05720, 388-71-05725, 388-71-05730, 388-71-05735, 388-71-05740, 388-71-05745, 388-71-05750, 388-71-05755, 388-71-05760, 388-71-05765, 388-71-05770, 388-71-05775, 388-71-05780, 388-71-05785, 388-71-05790, 388-71-05795, 388-71-05799, 388-71-05805, 388-71-05810,

388-71-05815, 388-71-05820, 388-71-05825, 388-71-05830, 388-71-05832, 388-71-05835, 388-71-05840, 388-71-05845, 388-71-05850, 388-71-05855, 388-71-05860, 388-71-05865, 388-71-05870, 388-71-05875, 388-71-05880, 388-71-05885, 388-71-05890, 388-71-05895, 388-71-05899, 388-71-05905, 388-71-05909, 388-71-0801, 388-71-0806, 388-71-0811, 388-71-0816, 388-71-0821, 388-71-0826, 388-112-0025, 388-112-0030, 388-112-0050, 388-112-0060, 388-112-0065, 388-112-0090, 388-112-0095, 388-112-0105, 388-112-0245, 388-112-02610, 388-112-02615, 388-112-02620, 388-112-02625, 388-112-02630 and 388-112-0375; and amending WAC 388-71-0500, 388-71-0505, 388-71-0510, 388-71-0513, 388-71-0515, 388-71-0520, 388-71-0540, 388-71-0546, 388-71-0551, 388-71-0560, 388-112-0001, 388-112-0005, 388-112-0010, 388-112-0015, 388-112-0035, 388-112-0040, 388-112-0045, 388-112-0055, 388-112-0070, 388-112-0075, 388-112-0080, 388-112-0085, 388-112-0110, 388-112-0115, 388-112-0120, 388-112-0125, 388-112-0130, 388-112-0135, 388-112-0140, 388-112-0145, 388-112-0150, 388-112-0155, 388-112-0160, 388-112-0165, 388-112-0195, 388-112-0200, 388-112-0205, 388-112-0210, 388-112-0220, 388-112-0225, 388-112-0230, 388-112-0235, 388-112-0240, 388-112-0255, 388-112-0260, 388-112-0270, 388-112-0295, 388-112-0300, 388-112-0315, 388-112-0320, 388-112-0325, 388-112-0330, 388-112-0335, 388-112-0340, 388-112-0345, 388-112-0350, 388-112-0355, 388-112-0360, 388-112-0365, 388-112-0370, 388-112-0380, 388-112-0385, 388-112-0390, 388-112-0395, 388-112-0405, and 388-112-0410.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520, Washington state 2009-11 budget (ESHB 1244, section 206(5)).

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: See above.

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 88, Amended 66, Repealed 72.

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 88, Amended 66, Repealed 72.

Date Adopted: December 22, 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 12-04 issue of the Register.

WSR 12-02-054

EMERGENCY RULES

DEPARTMENT OF LABOR AND INDUSTRIES

[Filed January 3, 2012, 8:27 a.m., effective January 3, 2012, 8:27 a.m.]

Effective Date of Rule: Immediately.

Purpose: Rule making is needed as part of the implementation of claim resolution structured settlement agreements, allowed by EHB 2123 (chapter 37, Laws of 2011). These agreements will be available for claims for injured workers age fifty-five and older effective January 1, 2012, fifty-three and older effective January 1, 2015, and fifty and older effective January 1, 2016. This rule making creates new rules to clarify requirements and the process for these agreements.

Statutory Authority for Adoption: RCW 51.04.020, 51.04.030, 51.04.065, 51.04.069 (chapter 37, Laws of 2011, EHB 2123).

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

Reasons for this Finding: Rule making is needed as part of the implementation of EHB 2123 (chapter 37, Laws of 2011) allowing claim resolution structured settlement agreements for injured workers age fifty-five and older effective January 1, 2012, fifty-three and older effective January 1, 2015, and fifty and older effective January 1, 2016. This change is expected to significantly impact costs of workers' compensation claims.

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 9, 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 9, Amended 0, Repealed 0.

Date Adopted: January 3, 2012.

Judy Schurke

Director

Chapter 296-14A WAC

CLAIM RESOLUTION STRUCTURED SETTLEMENT AGREEMENTS

NEW SECTION

WAC 296-14A-010 Negotiating settlements—How is a structured settlement agreement negotiated in a state fund claim? (1) In a state fund claim, any party may submit a structured settlement application form to the department.

(2) The department will perform an initial review and determine if negotiations should proceed. When deciding whether to enter into negotiations for a structured settlement, the department will consider the following nonexclusive factors:

(a) Worker's age;

(b) Nature and extent of injury(ies) or disease(s) related to the claim;

(c) Nature and extent of disabilities related to the condition(s) accepted under the claim;

(d) Other medical conditions unrelated to the claim;

(e) Other open or closed worker compensation claims for the worker;

(f) Other settlements for injuries or diseases;

(g) Worker's life expectancy;

(h) Worker's marital or domestic partnership status;

(i) Number and age of dependents;

(j) Worker's sources of present and future income and benefits;

(k) Worker's employment history;

(l) Worker's education history;

(m) Worker's labor market;

(n) The effect a structured settlement agreement might have on other benefits the worker is receiving or entitled to receive.

(3) If the department decides to negotiate, it will contact the other required parties and obtain their consent to move forward in negotiations, and obtain their consent about how the negotiations will be conducted. Negotiations may be conducted in-person, by phone, or by letter.

(4) If all of the parties voluntarily agree to a settlement, the department will put the agreement in writing. All parties must sign the agreement.

(5) After all parties have signed the structured settlement agreement, the department will forward a copy of the signed agreement to the board of industrial insurance appeals (BIIA), and provide any necessary documentation for the BIIA approval process.

NEW SECTION

WAC 296-14A-020 Employers. (1) **Who is an affected employer?** An employer is an affected employer if the cost of the claim which may be the subject of a structured settlement agreement is included in the calculation of the employer's experience factor used to determine premiums. The department will send notice of any structured settlement agreement negotiations to an affected employer.

(2) **How will an affected employer be notified of a structured settlement agreement negotiation?** When the department decides to begin settlement discussions, the department will notify all affected employers by mail, and will request the employer's participation in the negotiations.

(3) **How long does an affected employer have to respond to the department's notice of a negotiation?** An affected employer has fourteen calendar days from the date the notice is sent to respond to the department's request for participation.

(4) **What happens if an affected employer does not respond to the department's notice of a negotiation?** If the employer does not respond to the request within fourteen calendar days, the department will consider that the employer has declined to participate and will proceed with scheduling negotiations without the employer.

An affected employer who declines to participate as a party to a structured settlement agreement will be bound by the terms of the agreement including any impact the structured settlement may have on the employer's experience factor or on the employer's industrial insurance premiums.

NEW SECTION

WAC 296-14A-030 Continuation of benefits—Do Title 51 RCW benefits stop during settlement negotiations? The department or self-insured employer must continue to manage the industrial insurance claim and pay benefits to which the worker is entitled during any settlement negotiation until the agreement is final.

NEW SECTION

WAC 296-14A-040 Settlement issues—Can issues outside of Title 51 RCW be settled as part of a structured settlement agreement? No. Issues outside of Title 51 RCW including, but not limited to, continued employment or discrimination claims cannot be settled within the structured settlement agreement.

NEW SECTION

WAC 296-14A-050 Future claims—Can future claims be settled as part of a structured settlement? Future industrial injury or occupational disease claims may not be settled as part of a structured settlement. Future claims include, but are not limited to:

(1) Work-related injuries or occupational exposures that have not yet occurred;

(2) Applications for industrial injury or occupational disease benefits that have not yet been filed; and

(3) Claims for future death benefits or survivor benefits when the injured worker is still alive.

NEW SECTION

WAC 296-14A-060 Burden to Title 51 RCW funds—How does a self-insured employer obtain prior approval for a structured settlement agreement if the agreement will burden or impact any funds covered under Title 51 RCW? (1) If a self-insured employer is considering subjecting a fund covered under Title 51 RCW to any responsibility

or burden as a result of a structured settlement agreement, the self-insured employer will:

(a) Notify the department in writing and give the director or the director's designee at least thirty days to either approve or deny the request; and

(b) Provide the following information:

(i) A copy of the complete claim file(s) of the injured worker;

(ii) Any other information relevant to the proposed agreement; and

(iii) All terms of the structured settlement agreement, including an explanation of the anticipated impact on the fund(s).

(2) If settlement negotiations continue after the self-insured employer has notified the department of a structured settlement agreement that may impact any funds covered under Title 51 RCW, the self-insured employer will keep the department updated on all terms or information not previously provided.

NEW SECTION

WAC 296-14A-070 Protests—What if there is an outstanding protest on a claim that has a final settlement agreement? Any outstanding protests on a claim with a final settlement agreement are deemed to have been resolved by the agreement.

NEW SECTION

WAC 296-14A-080 Payments—What is a periodic payment schedule? Periodic payment for the purpose of RCW 51.04.063 structured settlements means payments that are made monthly unless the parties agree to a different payment schedule. In no case will payments be made more often than every two weeks.

NEW SECTION

WAC 296-14A-090 Prior agreements. (1) **How can I get a copy of a prior settlement agreement?** The department must keep copies of all final structured settlement agreements. Any party who is actively negotiating a new structured settlement agreement can request a copy of prior agreements involving the same worker, if any exist, from the department.

(2) **What is active negotiation?** Parties will be considered in active negotiations when the requirements of RCW 51.04.063(1) have been met, one hundred eighty days have passed since the claim was received by the department or self-insurer, the order allowing the claim is final and:

(a) All parties have agreed to attempt to resolve the claim(s) through a structured settlement agreement;

(b) The parties are discussing potential resolutions; and

(c) No resolution has been reached.

WSR 12-02-069
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-02—Filed January 3, 2012, 3:55 p.m., effective January 3, 2012, 3:55 p.m.]

Effective Date of Rule: Immediately.

Purpose: Allow officers to take into custody and, if necessary, destroy dogs that are pursuing, harassing, attacking, or killing deer, elk, and bighorn sheep.

Citation of Existing Rules Affected by this Order: Amending WAC 232-12-315.

Statutory Authority for Adoption: RCW 77.12.047, 77.04.020, and 77.12.315.

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

Reasons for this Finding: Weather conditions have forced deer, elk, and bighorn sheep to lower elevations, where harassment by dogs has been observed. In order to protect deer, elk, and bighorn sheep, it is necessary to allow officers to take into custody and, if necessary, destroy dogs that are pursuing, harassing, attacking or killing these animals. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: January 3, 2012.

Philip Anderson
Director

NEW SECTION

WAC 232-12-31500X Emergency for custody or destruction of dogs harassing deer and elk. Effective immediately until further notice, an emergency is declared in the following Washington State counties, making it permissible for Fish and Wildlife Officers to take into custody and, if necessary, destroy any dog that is pursuing, harassing, attacking or killing deer, elk, or bighorn sheep.

(1) Benton County
(2) Chelan County
(3) Douglas County
(4) Ferry County

(5) Franklin County
(6) Kitittas County
(7) Klickitat County
(8) Lincoln County
(9) Okanogan County
(10) Pend Oreille County
(11) Spokane County
(12) Stevens County
(13) Yakima County