WSR 14-01-064
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed December 13, 2013, 9:56 a.m., effective December 19, 2013]

Effective Date of Rule: December 19, 2013.

Purpose: To amend and add new sections to chapter 388-845 WAC, DDD home and community based services waivers, to be in compliance with the requirements of chapter 49, Laws of 2012 (SSB 6384) and related federal waivers recently renewed through Centers for Medicare and Medicaid Services (CMS). These changes add dental services as a waiver service and align this chapter with the changes being made to those in chapter 388-828 WAC for community services. This is a subsequent request to the previous emergency filed as WSR 13-17-122 on August 21, 2013.

Citation of Existing Rules Affected by this Order: Amending WAC 388-845-0110, 388-845-0205, 388-845-0210, 388-845-0215, 388-845-0220, 388-845-0225, 388-845-0505, 388-845-0800, 388-845-0820, 388-845-1110, 388-845-1105, 388-845-1150, 388-845-1400, 388-845-1410, 388-845-2110, 388-845-2205, and 388-845-2210.

Statutory Authority for Adoption: RCW 71A.12.030, 34.05.350 (1)(c).

Other Authority: Chapter 49, Laws of 2012.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that 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: The passing of chapter 49, Laws of 2012, required a tremendous amount [of] coordination and timing with CMS to agree on waiver language before we could develop new WAC language. Secondary, implementation of related programming changes to CARE (our statewide computer system) and aligning the language in these changes with those related sections of chapter 388-828 WAC. This emergency filing also adds dental as a waiver service. These changes were adopted by emergency on September 1, 2012, to be in compliance with what CMS had set for the changes to the waiver. The permanent rule was filed on November 26, 2013, as WSR 13-24-045 and will be effective on January 1, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 2, Amended 17, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.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 2, Amended 17, Repealed 0.

Date Adopted: December 12, 2013.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-20-050, filed 9/26/07, effective 10/27/07)

WAC 388-845-0110 Are there limitations to the waiver services I can receive? There are limitations to waiver services. In addition to the limitations to your access to nonwaiver services cited for specific services in WAC 388-845-0115, the following limitations apply:

(1) A service must be offered in your waiver and authorized in your plan of care or individual support plan.

(2) Mental health stabilization services may be added to your plan of care or individual support plan after the services are provided.

(3) Waiver services are limited to services required to prevent ICF/MR placement.

(4) The cost of your waiver services cannot exceed the average daily cost of care in an ICF/MR.

(5) Waiver services cannot replace or duplicate other available paid or unpaid supports or services.

(6) Waiver funding cannot be authorized for treatments determined by DSHS to be experimental.

(7) The Basic and Basic Plus waivers have yearly limits on some services and combinations of services. The combination of services is referred to as aggregate services ((~~or employment/day program services~~)).

(8) Your choice of qualified providers and services is limited to the most cost effective option that meets your health and welfare needs.

(9) Services provided out-of-state, other than in recognized bordering cities, are limited to respite care and personal care during vacations.

(a) You may receive services in a recognized out-of-state bordering city on the same basis as in-state services.

(b) The only recognized bordering cities are:

(i) Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston, Idaho; and

(ii) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria, Oregon.

(10) Other out-of-state waiver services require an approved exception to rule before DDD can authorize payment.

AMENDATORY SECTION (Amending WSR 08-20-033, filed 9/22/08, effective 10/23/08)

WAC 388-845-0205 Basic waiver services.

BASIC WAIVER	SERVICES	YEARLY LIMIT
	AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy Physical therapy Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	May not exceed $1454 per year on any combination of these services
	EMPLOYMENT((~~/DAY~~)) PROGRAM SERVICES: ((~~Community access~~)) Person-to-person Prevocational services Supported employment	((~~May not exceed $6804 per year~~)) Limits are determined by DDD assessment and employment status
	DAY PROGRAM SERVICES: Community access	Limits are determined by DDD assessment
	Sexual deviancy evaluation	Limits are determined by DDD
	Respite care	Limits are determined by the DDD assessment
	Personal care	Limits are determined by the CARE tool used as part of the DDD assessment
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services	Limits are determined by a mental health professional or DDD
	Skilled nursing Specialized psychiatric services	
	Emergency assistance is only for aggregate services and/or employment/day program services contained in the Basic waiver	$6000 per year; Preauthorization required

AMENDATORY SECTION (Amending WSR 08-20-033, filed 9/22/08, effective 10/23/08)

WAC 388-845-0210 Basic Plus waiver services.

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy Physical therapy Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	May not exceed $6192 per year on any combination of these services
	EMPLOYMENT((~~/DAY~~)) PROGRAM SERVICES: ((~~Community access~~ ~~Person-to-person~~)) Prevocational services Supported employment Individual technical assistance	((~~May not exceed $9944 per year~~)) ((~~This amount may be increased to a maximum of $19,888 per year by exception to rule based on client need~~)) Limits are determined by DDD assessment and employment status

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	DAY PROGRAM SERVICES: Community Access Adult foster care (adult family home) Adult residential care (boarding home)	Limits are determined by DDD assessment Determined per department rate structure
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD
	Personal care	Limits determined by the CARE tool used as part of the DDD assessment
	Respite care	Limits are determined by the DDD assessment
	Sexual deviancy evaluation	Limits are determined by DDD
	Emergency assistance is only for aggregate services ((~~and/or employment/day program services~~)) contained in the Basic Plus waiver	$6000 per year; Preauthorization required
	Adult dental services	Limits are determined by Chapter 182-535 WAC

AMENDATORY SECTION (Amending WSR 07-20-050, filed 9/26/07, effective 10/27/07)

WAC 388-845-0215 CORE waiver services.

CORE WAIVER	SERVICES	YEARLY LIMIT
	Behavior management and consultation	Determined by the plan of care or individual support plan, not to exceed the
	Community guide Community transition Environmental accessibility adaptations Occupational therapy Sexual deviancy evaluation Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	average cost of an ICF/MR for any combination of services
	Residential habilitation	
	Day program services Community access ((~~Person-to-person~~)) Employment program services Prevocational services Supported employment Individualized technical assistance	Limits are determined by assessment Limits are determined by DDD assessment and employment status
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD
	Personal care	Limits determined by the CARE tool used as part of the DDD assessment
	Respite care	Limits are determined by the DDD assessment
	Adult dental services	Limits are determined by chapter 182-535 WAC

AMENDATORY SECTION (Amending WSR 07-20-050, filed 9/26/07, effective 10/27/07)

WAC 388-845-0220 Community protection waiver services.

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
	Behavior management and consultation Community transition Environmental accessibility adaptations Occupational therapy Physical therapy Sexual deviancy evaluation Skilled nursing Specialized medical equipment and supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	Determined by the plan of care or individual support plan, not to exceed the average cost of an ICF/MR for any combination of services
	Residential habilitation	
	((~~Person-to-person~~)) Employment Program Services: Prevocational services Supported employment Individual technical assistance	Limits determined by DDD assessment and employment status
	Adult dental services	Limits are determined by chapter 182-535 WAC
	MENTAL HEALTH STABILIZATION SERVICES: Behavioral management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-0225 Children's intensive in-home behavioral support (CIIBS) waiver services.

CIIBS Waiver	Services	Yearly Limit
	• Behavior management and consultation • Staff/family consultation and training • Environmental accessibility adaptations • Occupational therapy • Physical therapy • Sexual deviancy evaluation • Nurse delegation • Specialized medical equipment / supplies • Specialized psychiatric services • Speech, hearing and language services • Transportation • Assistive technology • Therapeutic equipment and supplies • Specialized nutrition and clothing • Vehicle modifications	Determined by the individual support plan. Total cost of waiver services cannot exceed the average cost of $4,000 per month per participant.
	Personal care	Limits determined by the DDD assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.
	Respite care	Limits determined by the DDD assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.

CIIBS Waiver	Services	Yearly Limit
	Behavioral health Stabilization services: Behavioral support and consultation Crisis diversion bed services Specialized psychiatric services	Limits determined by mental health specialist

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-0505 Who is a qualified provider of behavior ((~~management~~)) support and consultation? Under the Basic, Basic Plus, Core, and Community Protection waivers, the provider of behavior ((~~management~~)) support and consultation must be one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

(1) Marriage and family therapist;

(2) Mental health counselor;

(3) Psychologist;

(4) Sex offender treatment provider;

(5) Social worker;

(6) Registered nurse (RN) or licensed practical nurse (LPN);

(7) Psychiatrist;

(8) Psychiatric advanced registered nurse practitioner (ARNP);

(9) Physician assistant working under the supervision of a psychiatrist;

(10) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW; ((~~or~~))

(11) Polygrapher; or

(12) State operated behavior support agency limited to behavioral health stabilization services.

NEW SECTION

WAC 388-845-0780 What is adult dental services? Adult dental services are provided to individuals age twenty-one years and older. Dental services provide comprehensive dental coverage as defined in chapter 182-535 WAC. Adult dental service coverage is limited to individuals on the Basic Plus, Core and Community Protection waivers.

NEW SECTION

WAC 388-845-0785 Who are qualified providers of adult dental services? Providers for adult dental services covered under the waiver program must have a current state license and have core provider agreement with the state medicaid agency.

AMENDATORY SECTION (Amending WSR 07-20-050, filed 9/26/07, effective 10/27/07)

WAC 388-845-0800 What is emergency assistance? Emergency assistance is a temporary increase to the yearly aggregate services and((~~/or employment/day program services~~)) dollar limit specified in the Basic and Basic Plus waiver when additional waiver services are required to prevent ICF/MR placement. These additional services are limited to the services provided in your waiver.

AMENDATORY SECTION (Amending WSR 07-20-050, filed 9/26/07, effective 10/27/07)

WAC 388-845-0820 Are there limits to my use of emergency assistance? All of the following limitations apply to your use of emergency assistance:

(1) Prior approval by the DDD regional administrator or designee is required based on a reassessment of your plan of care or individual support plan to determine the need for emergency services;

(2) Payment authorizations are reviewed every thirty days and cannot exceed six thousand dollars per twelve months based on the effective date of your current plan of care or individual support plan;

(3) Emergency assistance services are limited to the aggregate services ((~~and employment/day program services~~)) in the Basic and Basic Plus waivers;

(4) Emergency assistance may be used for interim services until:

(a) The emergency situation has been resolved; or

(b) You are transferred to alternative supports that meet your assessed needs; or

(c) You are transferred to an alternate waiver that provides the service you need.

AMENDATORY SECTION (Amending WSR 06-01-024, filed 12/13/05, effective 1/13/06)

WAC 388-845-1105 Who is a qualified provider of mental health crisis diversion bed services? Providers of mental health crisis diversion bed services must be:

(1) DDD certified residential agencies per chapter 388-101 WAC; ((~~or~~))

(2) Other department licensed or certified agencies; or

(3) State operated agency.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1110 What are the limits of mental health crisis diversion bed services? (1) Mental health crisis diversion bed services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) These services are available in the Basic, CIIBS, Basic Plus, Core, and Community Protection waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

(3) The costs of mental health crisis diversion bed services do not count toward the dollar limits for aggregate services in the Basic and Basic Plus waivers.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1150 What are mental health stabilization services? Mental health stabilization services assist persons who are experiencing a mental health crisis. These services are available in the Basic, Basic Plus, Core, CIIBS and Community Protection waivers to ((~~adults~~)) individuals determined by mental health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one of more of the following services:

(1) Behavior management and consultation;

(2) Specialized psychiatric services; or

(3) Mental health crisis diversion bed services.

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

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1400 What are prevocational services? (1) Prevocational services occur in a specialized or segregated settings and include monthly employment related activities in the community. Prevocational services are designed to prepare you for gainful employment in an integrated setting through training and skill development.

(2) Prevocational services are available in the Basic, Basic Plus, Core and Community Protection waivers.

AMENDATORY SECTION (Amending WSR 08-20-033, filed 9/22/08, effective 10/23/08)

WAC 388-845-1410 Are there limits to the prevocational services I can receive? The following limitations apply to your receipt of prevocational services:

(1) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school, or age twenty-two or older to receive prevocational services.

(2) New referrals for prevocational services require prior approval by the DDD regional administrator and county coordinator or their designees.

(3) Prevocational services are a time limited step on the pathway toward individual employment and are dependent on your demonstrating steady progress toward gainful employment over time. Your annual vocational assessment will include exploration of integrated settings within your next service year. Criteria that would trigger a review of your need for these services include, but are not limited to:

(a) Compensation at more than fifty percent of the prevailing wage;

(b) Significant progress made toward your defined goals;

(c) Your expressed interest in competitive employment; and/or

(d) Recommendation by your individual support plan team.

(4) You will not be authorized to receive prevocational services in addition to community access services or supported employment services.

(5) ((~~The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.~~

~~(6)~~)) Your service hours are determined by the assistance you need to reach your employment outcomes as described in WAC 388-828-9235.

AMENDATORY SECTION (Amending WSR 08-20-033, filed 9/22/08, effective 10/23/08)

WAC 388-845-2110 Are there limits to the supported employment services I can receive? The following limitations apply to your receipt of supported employment services:

(1) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school, or age twenty-two or older to receive supported employment services.

(2) Payment will be made only for the employment support you require as a result of your disabilities.

(3) Payment for individual supported employment excludes the supervisory activities rendered as a normal part of the business setting.

(4) You will not be authorized to receive supported employment services in addition to community access or prevocational services.

(5) ((~~The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of supported employment service you may receive.~~

~~(6)~~)) Your service hours are determined by the assistance you need to reach your employment outcomes as described in WAC 388-828-9235 and might not equal the number of hours you spend on the job or in job related activities.

AMENDATORY SECTION (Amending WSR 06-01-024, filed 12/13/05, effective 1/13/06)

WAC 388-845-2205 Who is qualified to provide transportation services? (1) The provider of transportation services can be an individual or agency contracted with DDD.

(2) For adult dental services only, provider can be contracted as a transportation broker through medicaid.

AMENDATORY SECTION (Amending WSR 08-20-033, filed 9/22/08, effective 10/23/08)

WAC 388-845-2210 Are there limitations to the transportation services I can receive? The following limitations apply to transportation services:

(1) Transportation to/from medical or medically related appointments is a medicaid transportation service and is to be considered and used first.

(2) Transportation is offered in addition to medical transportation but cannot replace medicaid transportation services.

(3) Transportation is limited to travel to and from a waiver service.

(4) Transportation does not include the purchase of a bus pass.

(5) Reimbursement for provider mileage requires prior approval by DDD and is paid according to contract.

(6) This service does not cover the purchase or lease of vehicles.

(7) Reimbursement for provider travel time is not included in this service.

(8) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

(9) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your provider's contract and payment.

(10) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive unless provided by a contracted transportation broker to access adult dental services.

(11) Transportation services require prior approval by the DDD regional administrator or designee, unless provided by transportation broker for adult dental services.

(12) If your individual personal care provider uses his/her own vehicle to provide transportation to you for essential shopping and medical appointments as a part of your personal care service, your provider may receive up to sixty miles per month in mileage reimbursement. If you work with more than one individual personal care provider, your limit is still a total of sixty miles per month. This cost is not counted toward the dollar limitation for aggregate services in the Basic or Basic Plus waiver.

WSR 14-02-020
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-302—Filed December 20, 2013, 12:06 p.m., effective December 23, 2013, 5:00 p.m.]

Effective Date of Rule: December 23, 2013, 5:00 p.m.

Purpose: Amend commercial fishing rules.

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

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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: This rule implements the closure of the Region 2 East and Region 2 West on December 23, 2013, at 5:00 p.m. The state will reach its full allocation in both of these regions at that time. This rule also maintains the closure of Region 1 that was implemented on December 4, 2013, at 5:00 p.m. Region[s] 3-1, 3-2 and 3-3 will remain open. There is sufficient allocation available in these commercial regions. These provisions are in conformity with agreed management plans with applicable tribes and management plans are entered into as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives negotiated with applicable treaty tribes and outlined in the management plans. There is insufficient time to adopt permanent rules.

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 2.

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

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

Date Adopted: December 20, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-52-04000D Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. Notwithstanding the provisions of WAC 220-52-040:

It is unlawful for any person to use, maintain, operate or control commercial crab gear in that portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123°7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

NEW SECTION

WAC 220-52-04600U Puget Sound crab fishery--Seasons and areas. Notwithstanding the provisions of WAC 220-52-046:

(1) The following areas are closed to commercial crab fishing:

(a) Effective immediately, until further notice, Crab Management Region 1. This region includes Marine Fish-Shellfish Management and Catch Reporting Areas 20A, 20B, 21A, 21B, 22A, and 22B.

(b) Effective 5:00 p.m., Monday, December 23, 2013, until further notice, Crab Management Region 2 East and Region 2 West will be closed. These regions include Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D, 26A East, 26A West, 25B and 25D.

(c) Effective immediately, until further notice, that portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123°7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(d) Effective immediately, until further notice, that portion of Marine Fish-Shellfish Management and Catch Report-

ing Area 23D west of a line from the eastern tip of Ediz Hook to the ITT Rayonier Dock.

REPEALER

The following sections of the Washington Administrative Code are repealed effective 5:00 p.m. December 23, 2013:

WAC 220-52-04000B	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts (13-295)
WAC 220-52-04600T	Puget Sound crab fishery—Seasons and areas (13-299)

WSR 14-02-032
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 13-303—Filed December 20, 2013, 4:50 p.m., effective December 29, 2013, 12:01 p.m.]

Effective Date of Rule: December 29, 2013, 12:01 p.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000F; and amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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

Reasons for this Finding: Survey results show that adequate razor clams are available for harvest in Razor Clam Areas 1, 3, 4 and 5. Washington department of health has certified clams from these beaches are safe for human consumption. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: December 20, 2013.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000F Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 3, 4, or 5, except as provided in this section:

(1) Effective 12:01 p.m. December 29, 2013 through 11:59 p.m. January 4, 2014, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

(2) Effective 12:01 p.m. December 29, 2013 through 11:59 p.m. January 5, 2014, razor clam digging is allowed in Razor Clam Area 3. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

(3) Effective 12:01 p.m. December 29 through 11:59 p.m. December 31, 2013, razor clam digging is allowed in Razor Clam Area 4. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

(4) Effective 12:01 p.m. January 4, 2014 through 11:59 p.m. January 4, 2014, razor clam digging is allowed in Razor Clam Area 4. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

(5) Effective 12:01 p.m. December 29, 2013 through 11:59 p.m. January 4, 2014, razor clam digging is allowed in Razor Clam Area 5. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

(6) It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries as defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. January 6, 2014:

WAC 220-56-3600F Razor clams—Areas and seasons.

Reviser's note: The section above appears as filed by the agency pursuant to RCW 34.08.040; however, the reference to WAC 220-56-3600F is probably intended to be WAC 220-56-36000F.

WSR 14-02-035
RECISSION OF EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

[Filed December 23, 2013, 12:08 p.m.]

Effective January 1, 2014, please rescind emergency rules filed as WSR 14-01-064 for chapter 388-845 WAC. Permanent rules filed on November 26, 2013, as WSR 13-24-045 become effective January 1, 2014.

Katherine I. Vasquez
Rules Coordinator

WSR 14-02-041

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 13-307—Filed December 23, 2013, 3:00 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: To amend cougar hunting rules described in WAC 232-28-297.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-29700E; and amending WAC 232-28-297.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.055, 77.12.047, and 77.12.150.

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: This change closes specific cougar hunt areas that have met or exceeded the area harvest guideline. Immediate action is necessary to protect cougars from overharvest in hunt areas that have met or exceeded the area harvest guideline.

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 23, 2013.

Philip Anderson
Director

NEW SECTION

WAC 232-28-29700F 2012-2013, 2013-2014, and 2014-2015 Cougar hunting seasons and regulations. Notwithstanding the provisions of WAC 232-28-297, effective January 1, 2014 until further notice:

General cougar seasons in Game Management Units (GMUs) 105, 117, 149, 154, 157, 162, 163, 328, 329, 335, 336, 340, 342, 346, 382, 388, 560, 574 and 578 are closed.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 232-28-29700E	2012-2013, 2013-2014, and 2014-2015 Cougar hunting seasons and regulations.

WSR 14-02-056

EMERGENCY RULES

HEALTH CARE AUTHORITY

(Medicaid Program)

[Filed December 26, 2013, 10:45 a.m., effective December 27, 2013]

Effective Date of Rule: December 27, 2013.

Purpose: In response to a court-approved settlement agreement, the agency is adopting WAC 182-531-1410, 182-531-1412, 182-531-1414, 182-531-1416, 182-531-1418, 182-531-1420, 182-531-1422, 182-531-1424, 182-531-1426, 182-531-1428, 182-531-1430, 182-531-1432, 182-531-1434 and 182-531-1436, concerning coverage for applied behavioral analysis (ABA) services for children with autism spectrum disorders. The new rules address prior authorization for services, evaluating and prescribing provider requirements, ABA provider requirements, and payment.

Statutory Authority for Adoption: RCW 41.05.021.

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: The agency has been working with stakeholders and experts in autism spectrum disorders to craft rules to ensure public health and safety; however, the agency must file an emergency WAC for the short-term to meet the agreed upon January 2, 2013, deadline.

The agency is proceeding with the permanent rule adoption process initiated by the CR-101 filed under WSR 12-14-100. The agency has been working closely with stakeholders to draft the permanent rule and anticipates filing the CR-102 sometime in early 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 14, 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 14, Amended 0, Repealed 0.

Date Adopted: December 26, 2013.

Kevin M. Sullivan
Rules Coordinator

NEW SECTION

WAC 182-531-1410 Applied behavior analysis (ABA)—Purpose. (1) Applied behavior analysis (ABA) assists children and their families to improve the core symptoms associated with autism spectrum disorders or other developmental disabilities for which there is evidence ABA is effective, per WAC 182-501-0165. ABA services support learning, skill development, and assistance in any of the following areas or domains: Social, behavior, adaptive, motor, vocational, and/or cognitive.

(2) The medicaid agency pays for ABA services when the services:

(a) Are covered;

(b) Are medically necessary;

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

(d) Are provided to clients meeting program and clinical eligibility criteria, as described in WAC 182-531-1414;

(e) Are within currently accepted standards of evidence-based medical practice;

(f) Do not replicate ABA services paid for by other state agencies using medicaid funds;

(g) Are completed in stages, as described in WAC 182-531-1418, 182-531-1420, and 182-531-1422;

(h) Are provided by qualified health care professionals, as described in WAC 182-531-1424;

(i) Are authorized, as required within this section, chapters 182-501 and 182-502 WAC, and the agency's applicable, published medicaid provider guides; and

(j) Are billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's applicable, published medicaid provider guides.

NEW SECTION

WAC 182-531-1412 Applied behavior analysis (ABA)—Definitions. The following definitions and those found in chapter 182-500 WAC, medical definitions, and chapter 182-531 WAC, physician-related services, apply to the medicaid agency's applied behavior analysis (ABA) program.

ABA therapy treatment plan - An individualized, goal-directed treatment plan developed by a lead behavior analysis therapist meeting the criteria in WAC 182-531-1424 (2)(a)(i)(A), in coordination with other members of the health care team, and that is inclusive of other services being provided by team members.

Applied behavior analysis or **ABA –** Applied behavior analysis (ABA) is an empirically validated approach to improve behavior and skills related to core impairments associated with autism and a number of other developmental disabilities. ABA involves the systematic application of scientifically validated principles of human behavior to change socially significant behaviors. ABA uses scientific methods to reliably demonstrate that behavioral improvements are caused by the prescribed interventions. ABA's focus on social significance promotes a family-centered and whole-life approach to intervention. Common methods used include: Assessment of behavior, caregiver interviews, direct observation, and collection of data on targeted behaviors. A single-case design is used to demonstrate the relationship between the environment and behavior as a means to implement client-specific ABA therapy treatment plans with specific goals and promote lasting change. ABA also includes the implementation of a functional behavior assessment to identify environmental variables that maintain challenging behavior and allow for more effective interventions to be developed that reduce challenging behaviors and teach appropriate replacement behaviors.

Autism - A diagnosis on the autism spectrum disorder, as defined by the most current diagnostic and statistical manual of mental disorders (DSM) criteria, and made or confirmed by an agency-recognized center of excellence (COE).

Autism diagnostic tool - A validated tool used to establish the presence (or absence) of autism and to make a definitive diagnosis which will be the basis for treatment decisions and assist in the development of a multidisciplinary clinical treatment plan. Examples of autism diagnostic tools include:

(a) Autism Diagnosis Interview (ADI); and

(b) Autism Diagnostic Observation Schedule (ADOS).

Autism screening tool - A tool used to detect indicators or risk factors for autism and may indicate a suspicion of the condition which would then require confirmation. Examples of screening tools include, but are not limited to:

(a) Ages and Stages Questionnaire (ASQ);

(b) Communication and Symbolic Behavior Scales (CSBS);

(c) Parent's Evaluation and Developmental Status (PEDS);

(d) Modified Checklist for Autism in Toddlers (MCHAT); and

(e) Screening Tools for Autism in Toddlers and young children (STAT).

Centers of excellence or **COE -** A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care. In this program, this term is applicable to the clinician(s) who establishes or confirms the diagnosis of an autism spectrum disorder and develops the multidisciplinary clinical treatment plan.

Comprehensive diagnostic evaluation – A medical/mental health evaluation performed by the center of excellence meeting the criteria in WAC 182-531-1418(2).

Day services program - An agency-approved, structured, nonresidential, facility-based group program designed to meet the needs of enrolled children through individualized ABA therapy plans of care. The program is comprehensive, providing a variety of health, social, therapeutic activities (occupational, speech, and physical therapy), supervision, support, and assistance with learning skills to perform activities of daily living, as needed.

Diagnostic and Statistical Manual of mental disorders (DSM) - A manual published by the American Psychiatric Association that provides a common language and standard criteria for the classification of mental disorders.

Family – Individuals who are in the role of parents, guardians, caregivers, and other primary support members to the child.

Lead behavior analysis therapist or **LBAT -** A person meeting the qualifications for lead behavior analysis therapist (LBAT) as described in WAC 182-531-1424 (2)(a).

Therapy assistant - A person meeting the qualifications for therapy assistant as described in WAC 182-531-1424 (2)(b)(ii) and having sufficient competence to perform the tasks of a therapy assistant as described in WAC 182-531-1424 (2)(b)(iii).

NEW SECTION

WAC 182-531-1414 Applied behavior analysis (ABA)—Client eligibility. To be eligible for applied behavior analysis (ABA) services, clients must meet all of the following:

(1) Program eligibility:

(a) Be twenty years of age and younger;

(b) Be covered under one of the following Washington apple health (WAH) programs:

(i) Children's health care as defined in WAC 182-505-0210;

(ii) Categorically needy program (CNP); or

(iii) Medically needy program (MNP).

(2) Clinical eligibility:

(a) The client's health care record contains documentation by a clinician that may incorporate family member observations or results of diagnostic screenings, or both, establishing the presence of any of the core symptoms of an autism spectrum disorder: Functional impairment; delay in communication, behavior, and/or social interaction; or repetitive or stereotyped behavior;

(b) There is documentation by a clinician which may incorporate family member observations, that the client's behaviors are having an adverse impact on either development or communication, or both, such that:

(i) The client cannot adequately participate in home, school, or community activities because the behavior or skill deficit(s) interferes with these activities; and/or

(ii) The child exhibits challenging behavior that negatively affects the safety or health of the child or others, or impedes access to home and community activities available to other children of the same age. Examples include, but are not limited to: Self-injury, aggression towards others, destruction of property, stereotyped/repetitive behaviors, elopement, or severe disruptive behavior; and

(c) The agency's recognized center of excellence (COE) has confirmed all requirements in (a) and (b) of this subsection and all of the following:

(i) The client has a diagnosis of an autism spectrum disorder, as defined by the most current DSM version;

(ii) Either of the following:

(A) That less intrusive or less intensive behavioral interventions have been tried and have not been successful; or

(B) That no equally effective and substantially less costly alternative is available for reducing interfering behaviors, increasing prosocial skills and behaviors, or maintaining desired behaviors; and

(iii) There is a reasonable calculation the requested services will result in measurable improvement in either the client's behavior, skills, or both.

NEW SECTION

WAC 182-531-1416 Applied behavior analysis (ABA)—Program stages. The following stages must be completed:

(1) Stage one - Referral to a center of excellence (COE) for evaluation, development of a multidisciplinary clinical treatment plan that may include applied behavior analysis (ABA), and an order/prescription for ABA;

(2) Stage two – Referral to an ABA provider (see WAC 182-531-1424 for who qualifies as an ABA provider) for an ABA assessment, which includes:

(a) A functional assessment;

(b) A skill assessment using a standardized tool, if indicated;

(c) A functional behavioral analysis, if indicated; and

(d) An ABA therapy treatment plan; and

(3) Stage three - Delivery of ABA services with the medicaid agency's authorization.

NEW SECTION

WAC 182-531-1418 Applied behavior analysis (ABA)—Stage one: Referral to a COE for evaluation and order. (1) A client who meets the eligibility criteria in WAC 182-531-1414 must be referred to a center of excellence (COE) for an evaluation and multidisciplinary clinical treatment plan by:

(a) The primary care provider or other licensed health care practitioner including, but not limited to, a speech therapist or occupational therapist;

(b) A school-based health care professional as the result of an individual education plan (IEP) or an early intervention health care professional as the result of an individualized family service plan (IFSP);

(c) The client's family; or

(d) The client's managed care plan, if applicable.

(2) The COE must provide a comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan that includes:

(a) Results of routine developmental screening performed by the child's primary care provider at well child visits, as available;

(b) Audiology and vision assessment results, as available, or documentation that vision and hearing were determined to be within normal limits during assessment and not a barrier to completing a valid evaluation;

(c) The name of the completed autism screening questionnaire, including date completed and significant results, as available;

(d) Documentation of how the diagnosis was made or confirmed by a COE physician or psychologist that includes:

(i) Results of formal diagnostic procedures performed by a clinician, including name of measure, dates, and results, as available; and/or

(ii) Clinical findings and observations used to confirm the diagnosis;

(e) If available, documentation of a formal cognitive and/or developmental assessment performed by the COE or another qualified clinician, including name of measure, dates, results, and standardized scores providing verbal, nonverbal, and full-scale scores. This may include school or early childhood education records. Examples of these assessment tools are:

(i) Mullen Scales of Early Learning;

(ii) Wechsler Individual Achievement Test; or

(iii) Bayley Scales of Infant and Toddler Development;

(f) If available, documentation of a formal adaptive behavior assessment performed by the COE or another qualified clinician, including name of measure, dates, results, and standardized scores providing scores of each domain. Examples of these assessment tools are:

(i) Vineland Adaptive Behavior Scales; or

(ii) Adaptive Behavior Assessment System (ABAS);

(g) Expanded laboratory evaluation, if indicated;

(h) Documentation that the client's behaviors or skill deficits are having an adverse impact on development or communication, or demonstrating injurious behavior, such that:

(i) The client cannot adequately participate in home, school, or community activities because behavior or skill deficit(s) interferes with these activities; or

(ii) The client presents a safety risk to self or others;

(i) Documentation that, if applied behavior analysis (ABA) is included in the multidisciplinary clinical treatment plan:

(i) Less intrusive or less intensive behavioral interventions have been tried and were not successful; or

(ii) There is no equally effective alternative available for reducing interfering behaviors, increasing prosocial behaviors, or maintaining desired behaviors;

(j) Recommendations that consider the full range of autism treatments with ABA as a treatment component, if clinically indicated;

(k) A statement that the evaluating and prescribing provider believes that there is a reasonable calculation that the requested ABA services will result in measurable improvement in the client's behavior or skills; and

(l) An order/prescription for ABA services. If ordered/prescribed, a copy of the COE's comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan must be forwarded to the family-selected ABA provider in WAC 182-531-1424(2) or provided to the family to forward to the selected ABA provider.

NEW SECTION

WAC 182-531-1420 Applied behavior analysis (ABA)—Stage two: ABA assessment and plan development. (1) If the center of excellence's (COE's) evaluating and prescribing provider orders applied behavior analysis (ABA) services, the client may begin stage two - ABA assessment, functional analysis, and ABA therapy treatment plan development.

(2) Prior to implementing the ABA therapy treatment plan, the ABA provider must receive prior authorization from the medicaid agency. The prior authorization request, including the assessment and ABA therapy treatment plan, must be received by the agency within sixty days of the family scheduling the functional assessment. The client and family select the setting in which to receive services and by which ABA provider. ABA services are rendered in one of the following settings:

(a) Day services program - This is an agency-approved, outpatient facility or clinic-based program that:

(i) Provides multidisciplinary services in a short-term day treatment program setting;

(ii) Delivers comprehensive intensive services;

(iii) Embeds early, intensive behavioral interventions in a developmentally appropriate context;

(iv) Provides a developmentally appropriate ABA therapy treatment plan for each child;

(v) Includes family support and training; and

(vi) Includes multidisciplinary team members as clinically indicated to include a lead behavior analysis therapist (LBAT), therapy assistant, occupational therapist, speech therapist, physical therapist, psychologist, medical clinician, and dietician.

(b) Home, office, clinic, and community-based program (i.e., natural setting) - This is a program that:

(i) May be used after discharge from a day services program (see (a) of this subsection);

(ii) Provides a developmentally appropriate ABA therapy treatment plan for each child;

(iii) Provides ABA services in the home (wherever the child resides), office, clinic, or community setting, as required to accomplish the goals in the ABA therapy treatment plan. Examples of community settings are: A park, restaurant, child care, early childhood education, or school and must be included in the ABA therapy treatment plan with services being provided by the medicaid-enrolled LBAT or therapy assistant approved to provide services via authorization;

(iv) Requires recertification of medical necessity through continued authorization; and

(v) Includes family education, support, and training.

(3) An assessment, as described in WAC 182-531-1416(2), must be conducted and an ABA therapy treatment plan developed by an LBAT in the chosen setting. The ABA therapy treatment plan must follow the agency's ABA therapy treatment plan report template and:

(a) Be signed by the LBAT responsible for the plan development and oversight;

(b) Be time-limited (e.g., three or six months) and based on the COE's comprehensive diagnostic evaluation (see WAC 182-531-1418(2)) that took place no more than twelve months before the ABA assessment;

(c) Address the behaviors, skill deficit(s), and symptoms that prevent the client from adequately participating in home, school, community activities, or present a safety risk to self or others;

(d) Be specific and individualized to the client;

(e) Be client-centered, family-focused, community-based, culturally competent, and minimally intrusive;

(f) Take into account all school or other community resources available to the client, assure that the requested services are not redundant, but are in coordination with, other

services already being provided or otherwise available, and coordinate services (e.g., from school and special education or from early intervention programs and early intervention providers) with other interventions and treatments (e.g., speech therapy, occupational therapy, physical therapy, family counseling, and medication management);

(g) Focus on family engagement and training;

(h) Identify and describe in detail the targeted behaviors and symptoms;

(i) Include objective, baseline measurement levels for each target behavior/symptom in terms of frequency, intensity, and duration, including use of curriculum-based measures, single-case studies, or other generally accepted assessment tools;

(j) Include a comprehensive description of treatment interventions, or type of treatment interventions, and techniques specific to each of the targeted behaviors/symptoms, (e.g., discrete trial training, reinforcement, picture exchange, communication systems, etc.) including documentation of the number of service hours, in terms of frequency and duration, for each intervention;

(k) Establish treatment goals and objective measures of progress for each intervention specified to be accomplished in the three- to six-month treatment period;

(l) Incorporate strategies for generalized learning skills;

(m) Integrate family education, goals, training, support services, and modeling and coaching family/child interaction;

(n) Incorporate strategies for coordinating treatment with school-based special education programs and community-based early intervention programs, and plan for transition through a continuum of treatments, services, and settings; and

(o) Include measurable discharge criteria and a discharge plan.

NEW SECTION

WAC 182-531-1422 Applied behavior analysis (ABA)—Stage three: Delivery of ABA services. (1) The medicaid agency requires prior authorization (PA) of applied behavior analysis (ABA) services prior to delivery. Documents that support the PA and that must be submitted to the agency for consideration, as described in WAC 182-501-0163, are:

(a) The comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan completed by the center of excellence (COE) described in WAC 182-531-1418(2);

(b) The ABA assessment and ABA therapy treatment plan described in WAC 182-531-1420(3); and

(c) Other documents required as described in the agency's medicaid provider guides.

(2) After the services are prior authorized, the ABA therapy treatment plan is implemented by the lead behavior analysis therapist (LBAT) or a therapy assistant in conjunction with other care team members. The LBAT is responsible for communicating and collaborating with other care team members to assure consistency in approaches to achieve treatment goals. If services are rendered by a therapy assistant, the therapy assistant must:

(a) Assess the client's response to techniques and report that response to the LBAT;

(b) Provide direct on-site services in the client's natural setting found in the home, office, clinic, or community, or in the day services program;

(c) Be directly supervised by an LBAT for a minimum of five percent of total direct care per week (e.g., one hour per twenty hours of care);

(d) Consult with the LBAT when considering modification to technique, when barriers and challenges occur that prohibit implementation of plan, and as otherwise clinically indicated (see WAC 182-531-1426 for appropriate procedures and physical interventions and WAC 182-531-1428 for prohibited procedures and physical interventions);

(e) Assure family involvement through modeling, coaching, and training to support generalization and maintenance of achieved behaviors;

(f) Keep documentation of each visit with the client and family to include targeted behavior, interventions, response, modifications in techniques, and a plan for the next visit, along with behavior tracking sheets that record and graph data collected for each visit; and

(g) Maintain documentation of family's confirmation that the visit occurred, recording signature, and date.

NEW SECTION

WAC 182-531-1424 Applied behavior analysis (ABA)—Provider requirements. (1) **Stage one.** The center of excellence's (COE's) evaluating and prescribing providers must function as a multidisciplinary team whether facility-based or practitioner-based.

(a) The qualifications for a COE are:

(i) The entity or individual employs:

(A) A person or persons licensed under Title 18 RCW who is experienced in the diagnosis and treatment of autism spectrum disorders and has a specialty in one of the following:

(I) Neurology;

(II) Pediatric neurology;

(III) Developmental pediatrics;

(IV) Psychology;

(V) Pediatric psychiatry; or

(VI) Psychiatry; and

(B) A licensed midlevel practitioner (i.e., advanced registered nurse practitioner (ARNP) or physician assistant (PA)) who has been trained by and works under the tutelage of one of the specialists in (a)(i)(A) of this subsection and meets the qualifications in (a)(ii) of this subsection; or

(C) Another qualified medical provider who, within the discretion of the medicaid agency, meets qualifications in (a)(ii) of this subsection.

(ii) The entity or individual has been prequalified by the medicaid agency as meeting or employing persons meeting the following criteria:

(A) For physicians or psychologists only, have sufficient expertise to diagnose an autism spectrum disorder using a validated diagnostic tool or to confirm the diagnosis through observing the client's behavior, reviewing the documentation available from the client's primary care provider, reviewing

the child's individualized education plan (IEP) or individualized family service plan (IFSP), and interviewing family members;

(B) Have sufficient experience in or knowledge of the medically necessary use of applied behavior analysis (ABA); and

(C) Are sufficiently qualified to conduct and document a comprehensive diagnostic evaluation, and to develop a multidisciplinary clinical treatment plan as described in WAC 182-531-1418(2); and

(iii) The entity or individual has a core provider agreement (CPA) with the agency or is a performing provider on an approved CPA with the agency, unless the client is covered under a managed care organization or has other third-party insurance.

(b) Examples of providers who can qualify and be paid for these services as a designated COE are:

(i) Multidisciplinary clinics;

(ii) Individual qualified provider offices; and

(iii) Neurodevelopmental centers.

(2) **Stages two and three.** Regardless of the service delivery option, ABA providers must meet the specified minimum qualifications and comply with applicable state laws.

(a) Lead behavior analysis therapist (LBAT).

(i) Requirements.

(A) The LBAT must be:

(I) Able to practice independently by being licensed by the department of health (DOH) as a physician, psychologist, or licensed mental health practitioner under Title 18 RCW in good standing with no license restrictions; or

(II) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DOH as a hospital, a residential treatment facility, or an in-home services agency with a home health service category to provide ABA services, and be able to practice independently by being licensed by DOH as a physician, psychologist, licensed mental health practitioner, or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(III) Employed or contracted with an agency that is enrolled as a participating provider and licensed by the department of social and health services' division of behavioral health and recovery (DBHR) with certification to provide ABA services, and be able to meet the staff requirements specified in chapter 388-877A WAC.

(B) The LBAT must:

(I) Enroll as a performing/servicing provider and be authorized to supervise ancillary providers; and

(II) Be a board-certified behavior analyst (BCBA) with proof of board certification through the Behavior Analysis Certification Board; or

(III) Either have two hundred forty hours of course work related to behavior analysis and seven hundred fifty hours of supervision under a BCBA, or have two years of practical experience in designing and implementing comprehensive ABA therapy treatment plans.

(ii) Role. The LBAT must:

(A) Develop and maintain an ABA therapy treatment plan that is comprehensive, incorporating treatment being provided by other health care professionals, and that states how all treatment will be coordinated, as applicable; and

(B) Supervise a minimum of five percent of the total direct care provided by the therapy assistant per week (e.g., one hour per twenty hours of care).

(b) Therapy assistant. Requirements.

(i) Therapy assistants must be:

(A) Able to practice independently by being licensed by DOH as a licensed mental health practitioner or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(B) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DOH as a hospital, a residential treatment facility, or an in-home services agency with a home health service category to provide ABA services, and be able to practice independently by being licensed by DOH as a licensed mental health practitioner or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(C) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DBHR as a community mental health agency with certification to provide ABA services, and be able to meet the staff requirements specified in chapter 388-877A WAC;

(ii) The therapy assistant must:

(A) Have sixty hours of ABA training that includes applicable ABA principles and techniques, services, and caring for a child with core symptoms of autism; and

(B) Have a written letter of attestation signed by the lead LBAT that the therapy assistant has demonstrated competency in implementing ABA therapy treatment plans and delivering ABA services prior to providing services without supervision to covered clients; and

(C) Enroll as a performing/servicing provider.

(iii) Role. The therapy assistant must:

(A) Deliver services according to the ABA therapy treatment plan; and

(B) Be supervised by an LBAT who meets the requirements in (a)(i) of this subsection; and

(C) Review the ABA therapy treatment plan and the client's progress with the LBAT at least every two weeks for documentation of supervision, and make changes as indicated by the child's response.

(c) Licensure for facility-based day program setting. This applies to the model described in WAC 182-531-1420 (2)(a). Outpatient hospital facilities providing these services must meet the applicable DOH licensure requirements. Clinics and nonhospital-based facilities providing these services must be licensed as a community mental health agency by DBHR, as described in chapter 388-877A WAC. Providers rendering direct ABA services must meet the qualifications and applicable licensure or certification requirements as described in this subsection, as applicable. Other providers serving as members of the multidisciplinary care team must be licensed or certified under Title 18 RCW, as required.

NEW SECTION

WAC 182-531-1426 Applied behavior analysis (ABA)—Protective restrictive procedures and physical

interventions. In the course of receiving applied behavior analysis (ABA) services, when a client's behavior presents a threat of injury to self or others or significant damage to property, steps must be taken to protect the client and others from harm, or to prevent significant property damage.

(1) Protective restrictive procedures include, but are not limited to:

(a) Requiring a client to leave an area with physical force (i.e., physically holding and moving the client) for protection of the client, others, or property;

(b) Physical restraint to prevent the free movement of part or all of the client's body when the client's behavior poses an immediate risk to physical safety. Restraint in a prone or supine position (i.e., with the client lying on the stomach or back, respectively) is prohibited; and

(c) Mechanical restraint that limits the client's free movement or prevents self-injurious behavior (e.g., a helmet for head-banging, hand mittens or arm splints for biting, etc.). Mechanical restraint in a prone position (lying on the stomach) is prohibited.

(2) Protective physical interventions include, but are not limited to:

(a) Hand, arm, and leg holds;

(b) Standing holds;

(c) Physically holding and moving a client who is resisting; and

(d) Head holds. Physical control of the head is permitted only to interrupt biting or self-injury such as head banging.

NEW SECTION

WAC 182-531-1428 Applied behavior analysis (ABA)—Prohibited procedures and physical restrictions. The medicaid agency prohibits the use of the following procedures and physical restrictions for clients receiving applied behavior analysis (ABA) services:

(1) Procedures that are prohibited include:

(a) Corporal/physical punishment;

(b) The application of any electric shock or stimulus to a client's body;

(c) Forced compliance, including exercise, when it is not for protection;

(d) Locking a client alone in a room;

(e) Overcorrection;

(f) Physical or mechanical restraint in a prone position where the client is lying on his/her stomach;

(g) Physical restraint in a supine position where the client is lying on his/her back;

(h) Removing, withholding, or taking away money, tokens, points, or activities that a client has previously earned;

(i) Requiring a client to re-earn money or items purchased previously;

(j) Withholding or modifying food as a consequence for behavior (e.g., withholding dessert because the client was aggressive);

(k) Restraint chairs; and

(l) Restraint boards.

(2) Physical interventions using any of the following are not permitted under any circumstances:

(a) Any intervention that causes pain to the client and/or uses pressure points (whether for brief or extended periods);

(b) Obstruction of the client's airway and/or excessive pressure on the chest, lungs, sternum, and diaphragm;

(c) Hyperextension (pushing or pulling limbs, joints, fingers, thumbs or neck beyond normal limits in any direction) or putting the client in significant risk of hyperextension;

(d) Joint or skin torsion (twisting/turning in opposite directions);

(e) Direct physical contact covering the face;

(f) Straddling or sitting on the torso;

(g) Any of the following specific physical techniques:

(i) Arm or other joint locks (e.g., holding one or both arms behind back and applying pressure, pulling or lifting);

(ii) A "sleeper hold" or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;

(iii) Wrestling holds, body throws, or other martial arts techniques;

(iv) Prone restraint (client lying on the stomach);

(v) Supine restraint (client lying on the back);

(vi) A head hold where the client's head is used as a lever to control movement of other body parts;

(vii) Any maneuver that forces the client to the floor on his/her knees or hands and knees;

(viii) Any technique that keeps the client off balance (e.g., shoving, tripping, pushing on the backs of the knees, pulling on the client's legs or arms, swinging or spinning the client around, etc.); and

(ix) Any technique that restrains a client face-first vertically against a wall or post.

(h) Excessive force (i.e., using more force than is necessary; beyond resisting with like force);

(i) Any maneuver that involves punching, hitting, slapping, poking, pinching or shoving the client;

(j) Use of bed side rails for staff convenience or to purposely restrain a client unnecessarily.

NEW SECTION

WAC 182-531-1430 Applied behavior analysis (ABA)—Covered services. (1) The medicaid agency covers only the following ABA services delivered in settings described in stage two, as noted in WAC 182-531-1420 (1) and (2), for eligible clients:

(a) The ABA assessments to determine the relationship between environmental events and behaviors;

(b) The direct provision of ABA services by the therapy assistant or lead behavior analysis therapist (LBAT);

(c) Initial ABA assessment and development of a written, initial ABA therapy treatment plan, limited to one per year;

(d) Additional ABA assessments and revisions of the initial ABA therapy treatment plan to meet client's needs, limited to four per year;

(e) Supervision of the therapy assistant;

(f) Training of family members to carry out the approved ABA therapy treatment plans;

(g) Observation of the family (or other plan implementer) and the individual's behavior to assure correct implementation of the approved ABA therapy treatment plan;

(h) Observation of the client's behavior to determine the effectiveness of the approved ABA therapy treatment plan; and

(i) On-site assistance in a difficult or crisis situation.

(2) The agency covers the following services, which may be provided in conjunction with ABA services under other agency programs and be consistent with the program rules:

(a) Speech and language therapy;

(b) Occupational therapy;

(c) Physical therapy;

(d) Counseling;

(e) Interpreter services;

(f) Dietician services; and

(g) Transportation services.

(3) The agency does not authorize payment of ABA services if the services are duplicative of services being rendered in another setting.

(4) Limits in amount or frequency of the covered services described in this section are subject to the provisions in WAC 182-501-0169, limitation extension.

NEW SECTION

WAC 182-531-1432 Applied behavior analysis (ABA)—Noncovered services. The medicaid agency does not cover the following services including, but not limited to:

(1) Autism camps;

(2) Dolphin therapy;

(3) Equine therapy/hippo therapy;

(4) Language development training;

(5) Primarily educational services;

(6) Recreational therapy;

(7) Respite care;

(8) Safety monitoring services;

(9) School-based health care services or early intervention program-based services, unless prior authorized and as described in WAC 182-531-1420 (2)(b)(iii);

(10) Vocational rehabilitation;

(11) Life coaching; and

(12) Treatment that is unproven or investigational (e.g., holding therapy, Higashi (day life therapy), auditory integration therapy, etc.).

NEW SECTION

WAC 182-531-1434 Applied behavior analysis (ABA)—Prior authorization and recertification of ABA services. (1) The medicaid agency requires prior authorization (PA) and recertification of the medical necessity of applied behavior analysis (ABA) services.

(2) Requirements for PA requests are described in WAC 182-531-1422(1).

(3) The agency may reduce or deny services requested based on medical necessity (refer to subsection (5) of this section) when completing PA or recertification responsibilities.

(4) The following are requirements for recertification of ABA services:

(a) Continued ABA services require the agency's authorization. Authorization is granted in three-month increments, or longer at the agency's discretion;

(b) The lead behavior analysis therapist (LBAT) must request authorization for continuing services three weeks prior to the expiration date of the current authorization. A reevaluation and revised ABA therapy treatment plan documenting the client's progress and showing measurable changes in the frequency, intensity, and duration of the targeted behavior/symptoms addressed in the previously authorized ABA therapy treatment plan must be submitted with this request. Documentation must include:

(i) Projection of eventual outcome;

(ii) Assessment instruments;

(iii) Developmental markers of readiness; and

(iv) Evidence of coordination with providers; and

(c) In deciding whether to authorize continued ABA services, the agency may obtain the evaluating and prescribing center of excellence (COE) provider's review and recommendation. This COE provider must review the ABA therapy treatment plan, conduct a face-to-face visit with the child, facilitate a multidisciplinary record review of the client's progress, hold a family conference, or request a second opinion before recommending continued ABA services. Services will continue pending recertification.

(5) Basis for denial and/or reduction of services includes, but is not limited to, the following:

(a) Lack of medical necessity, for example:

(i) Failure to respond to ABA services, even after trying different ABA techniques and approaches, if applicable; or

(ii) Absence of meaningful, measurable, functional improvement changes or progress has plateaued without documentation of significant interfering events (e.g., serious physical illness, major family disruption, change of residence, etc.), if applicable. For changes to be meaningful they must be:

(A) Confirmed through data;

(B) Documented in charts and graphs;

(C) Durable over time beyond the end of the actual treatment session; and

(D) Generalizable outside of the treatment setting to the client's residence and the larger community within which the client resides; or

(b) Noncompliance as demonstrated by a pattern of failure of the family to:

(i) Keep appointments;

(ii) Attend treatment sessions;

(iii) Attend scheduled family training sessions;

(iv) Complete homework assignments; and

(v) Apply training as directed by the therapy assistant or LBAT. Absences that are reasonably justified (e.g., illness) are not considered part of the pattern.

NEW SECTION

WAC 182-531-1436 Applied behavior analysis (ABA)—Services provided via telemedicine. (1) Telemedicine is when a health care practitioner uses HIPAA compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered

services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows medicaid agency clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

(2) Telemedicine may be used to provide the following authorized services:

(a) Program supervision when the client is present; and

(b) Family training, which does not require the client's presence.

(3) The lead behavior analysis therapist (LBAT):

(a) May use telemedicine to supervise the therapy assistant's delivery of ABA services to the client and/or family; and

(b) Is responsible for determining that telemedicine can be performed without compromising the outcome of the ABA therapy treatment plan.

(4) The agency does not cover the following services as telemedicine:

(a) E-mail, telephone, and facsimile transmissions;

(b) Installation or maintenance of any telecommunication devices or systems; or

(c) Purchase, rental, or repair of telemedicine equipment.

(5) **Originating site.** An originating site is the physical location of the eligible agency client at the time the professional service is provided by the LBAT through telemedicine. The originating site is eligible to be paid a facility fee per completed transmission. Approved originating sites are:

(a) Clinic;

(b) Community setting;

(c) Home;

(d) Office; and

(e) Outpatient facility.

(6) **Distance site.** A distant site is the physical location where the LBAT provides the services listed in subsection (2) of this section to an eligible agency client through telemedicine.

(7) To be paid for providing ABA services via telemedicine, providers must bill the agency using the agency's current published *Applied Behavior Analysis (ABA) Medicaid Provider Guide*.

(8) If the LBAT or therapy assistant performs a separately identifiable service for the client on the same day as the telemedicine service, documentation for both services must be clearly and separately identified in the client's medical record.

WSR 14-02-076
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:45 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The health care authority is amending the estate recovery policy for medicaid in order to eliminate a barrier to applying for health care coverage under the Affordable Care Act. Currently, state regulation mandates the cost of all medicaid services be subject to state recovery. A client's estate will no longer be liable for the cost of medicaid services received by the client, other than long-term care services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-527-2742.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148).

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: This rule is necessary to remove a financial barrier to applying for health care coverage under the Affordable Care Act. For the Affordable Care Act to be implemented successfully, it is important to get as many people as possible to apply for health care coverage through the health benefit exchange.

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

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 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 30, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-19-038, filed 9/11/13, effective 10/12/13)

WAC 182-527-2742 Services subject to recovery. The medicaid agency or its designee considers the medical services the client received and the dates when the services were provided to the client, in order to determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for medicaid services, subsection (2) of this section covers liability for state-only funded long-term care services, and subsection (3) of this section covers liability for all other state-funded services. An estate can be liable under any of these subsections.

(1) The client's estate is liable for:

(a) All medicaid services provided from July 26, 1987, through June 30, 1994;

(b) The following medicaid services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medicaid services provided after June 30, 1995, and before June 1, 2004:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and long-term support administration of the department of social and health services (DSHS); and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(d) The following services provided on and after June 1, 2004, through December 31, 2009:

(i) All medicaid services, including those services described in subsection (c) of this section;

(ii) Medicare savings programs services for individuals also receiving medicaid;

(iii) Medicare premiums only for individuals also receiving medicaid; and

(iv) Premium payments to managed care organizations.

(e) The following services provided on or after January 1, 2010, through December 31, 2013:

(i) All medicaid services except those ((~~defined under~~)) described in (d)(ii) and (iii) of this subsection;

(ii) All institutional medicaid services described in (c) of this subsection (((~~(c) of this section~~));

(iii) Premium payments to managed care organizations; and

(iv) The client's proportional share of the state's monthly contribution to the centers for medicare and medicaid services (CMS) to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(f) The following services provided after December 31, 2013:

(i) Nursing facility services, including those provided in a developmental disabilities administration (DDA) residential habilitation center (RHC);

(ii) Home and community-based services authorized by the aging and long-term supports administration (ALTSA) or DDA, as follows:

(A) Community options program entry system (COPES);

(B) New Freedom consumer directed services (NFCDS);

(C) Basic Plus waiver;

(D) CORE waiver;

(E) Community protection waiver;

(F) Children's intensive in-home behavioral support (CIIBS) waiver;

(iii) The portion of the Washington apple health (WAH) managed care premium used to pay for long-term care services under the program of all-inclusive care for the elderly (PACE) authorized by ALTSA;

(iv) The portion of the WAH managed care premium used to pay for long-term care services under the Washington medicaid integration partnership (WMIP) authorized by ALTSA or DDA;

(v) Roads to community living (RCL) demonstration project;

(vi) Personal care services funded under Title 19 or 21;

(vii) Private duty nursing administered by ALTSA or DDA;

(viii) Intermediate care facility for individuals with intellectual disabilities (ICF/ID) services provided in either a private community setting or in an RHC;

(ix) Hospital and prescription drug services provided to a client while receiving services under subsection (1)(f)(i) through (viii) of this section;

(x) Client's proportional share of the state's monthly contribution to the Centers for Medicare and Medicaid Services (CMS) to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(2) The client's estate is liable for all state-only funded long-term care services (excluding the services listed in subsection (3)(a) through (d) of this section) and related hospital and prescription drug services provided to:

(a) Clients of the home and community services division of DSHS on and after July 1, 1995; and

(b) Clients of the developmental disabilities administration of DSHS on and after June 1, 2004.

(3) The client's estate is liable for all state-funded services provided regardless of the age of the client at the time the services were provided, with the following exceptions:

(a) State-only funded adult protective services (APS);

(b) Supplemental security payment (SSP) authorized by DDA;

(c) Offender reentry community safety program (ORCSP); and

(d) Volunteer chore services.

WSR 14-02-077
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:46 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The agency is amending WAC 182-502-0002 and 182-502-0003 in response to amendments the agency is making to chapter 182-531 WAC for applied behavior analysis, filed under WSR 12-14-100 on July 7, 2012; and chapter 182-543 WAC for complex rehabilitation technology, filed under WSR 13-15-072 on July 16, 2013.

Citation of Existing Rules Affected by this Order: Amending WAC 182-502-0002 and 182-502-0003.

Statutory Authority for Adoption: RCW 41.05.021; chapter 178, Laws of 2013 (E2SHB 1445); and 3ESSB 5034, section 213, Line 40, chapter 4, Laws of 2013, 63rd legislature.

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: Emergency adoption of these rules is necessary to allow the following providers to be eligible for agency reimbursement:

1. Applied behavior analysis (ABA) providers - In response to a court-approved settlement agreement, the agency is adopting rules concerning coverage for ABA services for children with autism spectrum disorders.

2. Suppliers of complex rehabilitation technologies (CRT) - As directed by the legislature in E2SHB 1445, the agency is establishing rules for a separate recognition for individually configured, CRT products and services for complex medical-need clients in the medical assistance program.

3. Naturopathic physicians - As directed by the legislature in ESSB [3ESSB] 5034, the agency will reimburse for primary care services provided by naturopathic physicians.

The agency is proceeding with the permanent rule adoption process. The agency sent draft of the rules to external stakeholders on December 11, 2013, and anticipates filing the CR-102 in early 2014.

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 2, 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 2, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

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

WAC 182-502-0002 Eligible provider types. The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state ((~~department of social and health services~~)) health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include((~~s~~)) treatment, equipment, related supplies, and drugs.

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesiologists;

(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531-1410 through 182-531-1436:

(i) Certified agency-affiliated counselors;

(ii) Certified counselors; and

(iii) Certified counselor advisors.

(d) Audiologists;

((~~(d)~~)) (e) Chemical dependency professionals:

(i) Mental health care providers; and

(ii) Peer counselors.

((~~(e)~~)) (f) Chiropractors;

((~~(f)~~)) (g) Dentists;

((~~(g)~~)) (h) Dental hygienists;

((~~(h)~~)) (i) Denturists;

((~~(i)~~)) (j) Dietitians or nutritionists;

((~~(j)~~)) (k) Hearing aid fitters/dispensers;

((~~(k)~~)) (l) Marriage and family therapists((~~, only as provided in WAC 388-531-1400~~));

((~~(l)~~)) (m) Mental health counselors((~~, only as provided in WAC 388-531-1400~~));

((~~(m)~~)) (n) Mental health care providers;

((~~(n)~~)) (o) Midwives;

((~~(o)~~)) (p) Naturopathic physicians;

(q) Nurse anesthetist;

(r) Occularists;

((~~(p)~~)) (s) Occupational therapists;

((~~(q)~~)) (t) Ophthalmologists;

((~~(r)~~)) (u) Opticians;

((~~(s)~~)) (v) Optometrists;

((~~(t)~~)) (w) Orthodontists;

((~~(u)~~)) (x) Orthotist;

((~~(v)~~)) (y) Osteopathic physicians;

((~~(w)~~)) (z) Osteopathic physician assistants;

((~~(x)~~)) (aa) Peer counselors;

((~~(y)~~)) (bb) Podiatric physicians;

((~~(z)~~)) (cc) Pharmacists;

((~~(aa)~~)) (dd) Physicians;

((~~(bb)~~)) (ee) Physician assistants;

((~~(cc)~~)) (ff) Physical therapists;

((~~(dd)~~)) (gg) Prosthetist;

((~~(ee)~~)) (hh) Psychiatrists;

((~~(ff)~~)) (ii) Psychologists;

((~~(gg)~~)) (jj) Radiologists;

((~~(hh)~~)) (kk) Registered nurse delegators;

((~~(ii)~~)) (ll) Registered nurse first assistants;

((~~(jj)~~)) (mm) Respiratory therapists;

((~~(kk)~~)) (nn) Social workers((~~, only as provided in WAC 388-531-1400~~)); and

((~~(ll)~~)) (oo) Speech/language pathologists.

(2) Agencies, centers and facilities:

(a) Adult day health centers;

(b) Ambulance services (ground and air);

(c) Ambulatory surgery centers (medicare-certified);

(d) Birthing centers (licensed by the department of health);

(e) ((~~Blood banks;~~

~~(f)~~)) Cardiac diagnostic centers;

((~~(g)~~)) (f) Case management agencies;

((~~(h)~~)) (g) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of ((~~alcohol and substance abuse (DASA)~~)) behavioral health and recovery (DBHR), and contracted through either:

(i) A county under chapter 388-810 WAC; or

(ii) ((~~DASA~~)) DBHR to provide chemical dependency treatment services.

((~~(i)~~)) (h) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by ((~~DASA~~)) DBHR);

((~~(j)~~)) (i) Community AIDS services alternative agencies;

((~~(k)~~)) (j) Community mental health centers;

((~~(l)~~)) (k) Diagnostic centers;

((~~(m)~~)) (l) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;

((~~(n)~~)) (m) Family planning clinics;

((~~(o)~~)) (n) Federally qualified health centers (designated by the federal department of health and human services);

((~~(p)~~)) (o) Genetic counseling agencies;

((~~(q)~~)) (p) Health departments;

((~~(r)~~)) (q) Health maintenance organization (HMO)/managed care organization (MCO);

((~~(s)~~)) (r) HIV/AIDS case management;

((~~(t)~~)) (s) Home health agencies;

((~~(u)~~)) (t) Hospice agencies;

((~~(v)~~)) (u) Hospitals;

((~~(w)~~)) (v) Indian health service facilities/tribal 638 facilities;

((~~(x)~~)) (w) Tribal or urban Indian clinics;

((~~(y)~~)) (x) Inpatient psychiatric facilities;

((~~(z)~~)) (y) Intermediate care facilities for the mentally retarded (ICF-MR);

((~~(aa)~~)) (z) Kidney centers;

((~~(bb)~~)) (aa) Laboratories (CLIA certified);

((~~(cc)~~)) (bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;

((~~(dd)~~)) (cc) Neuromuscular and neurodevelopmental centers;

((~~(ee)~~)) (dd) Nurse services/delegation;

((~~(ff)~~)) (ee) Nursing facilities (approved by the DSHS aging and ((~~disability services~~)) long-term support administration);

((~~(gg)~~)) (ff) Pathology laboratories;

((~~(hh)~~)) (gg) Pharmacies;

((~~(ii)~~)) (hh) Private duty nursing agencies;

((~~(jj)~~)) (ii) Radiology - Stand-alone clinics;

((~~(kk)~~)) (jj) Rural health clinics (medicare-certified);

((~~(ll)~~)) (kk) School districts and educational service districts;

((~~(mm)~~)) (ll) Sleep study centers; and

((~~(nn)~~)) (mm) Washington state school districts and educational service districts.

(3) Suppliers of:

(a) Blood, blood products, and related services;

(b) Durable and nondurable medical equipment and supplies;

((~~(b)~~)) (c) Complex rehabilitation technologies;

(d) Infusion therapy equipment and supplies;

((~~(c)~~)) (e) Prosthetics/orthotics;

((~~(d)~~)) (f) Hearing aids; and

((~~(e) Oxygen~~)) (g) Respiratory care, equipment, and supplies.

(4) Contractors:

(a) Transportation brokers;

(b) Spoken language interpreter services agencies;

(c) Independent sign language interpreters; and

(d) Eyeglass and contact lens providers.

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

WAC 182-502-0003 Noneligible provider types. The ((~~department~~)) medicaid agency does not enroll licensed or unlicensed health care practitioners not specifically listed in WAC ((~~388-502-0002~~)) 182-502-0002, including, but not limited to:

(1) Acupuncturists;

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

~~(3)~~)) Sanipractors;

((~~(4) Naturopaths;~~

~~(5)~~)) (3) Homeopaths;

((~~(6)~~)) (4) Herbalists;

((~~(7)~~)) (5) Massage therapists;

((~~(8) Social workers, except as provided in WAC 388-531-1400 and 388-537-0350;~~

~~(9)~~)) (6) Christian science practitioners, theological healers, and spiritual healers;

((~~(10)~~)) (7) Chemical dependency professional trainee (CDPT); and

((~~(11)~~)) (8) Mental health trainee (MHT).

WSR 14-02-078
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:46 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: These rule revisions are necessary to: (1) Add new section for coverage of alcohol and substance misuse counseling through screening, brief intervention, and referral to treatment (SBIRT); (2) new section for coverage for tobacco cessation counseling for pregnant clients; (3) add habilitative services under covered services; (4) remove oral health care services for emergency conditions for clients twenty-one and older from the covered section as a result of adult dental benefit restoration in chapter 182-535 WAC, effective January 1, 2014; (5) remove routine or nonemergency medical and surgical dental services for clients twenty-one years of age and older from the noncovered section; (6) updated who can bill for physician-related and health care professional services; (7) added naturopathic physicians to list of who can bill for osteopathic manipulative treatment; (8) revised WAC 182-531-1400 psychiatric physician-related services and other professional mental health services to remove mental health parity; and (9) add new section for coverage of telemedicine.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-531-1025; and amending WAC 182-

531-0100, 182-531-0150, 182-531-0250, 182-531-0800, 182-531-1050, and 182-531-1400.

Statutory Authority for Adoption: RCW 41.05.021; 3ESSB 5034 (section 213, chapter 4, Laws of 2013).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, 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: These emergency rules are necessary to meet the requirements in 3ESSB 5034, section 213, chapter 4, Laws of 2013, 63rd legislature, effective January 1, 2014.

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 2, 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 1, Amended 1, Repealed 1.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 3, Amended 6, Repealed 1.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-18-035, filed 8/28/13, effective 9/28/13)

WAC 182-531-0100 Scope of coverage for physician-related and health care professional services—General and administrative. (1) The medicaid agency covers health care services, equipment, and supplies listed in this chapter, according to agency rules and subject to the limitations and requirements in this chapter, when they are:

(a) Within the scope of an eligible client's ((~~medical assistance~~)) Washington apple health (WAH) program. Refer to WAC 182-501-0060 and 182-501-0065; and

(b) Medically necessary as defined in WAC 182-500-0070.

(2) The agency evaluates a request for a service that is in a covered category under the provisions of WAC ((~~182-501-0065~~)) 182-501-0165.

(3) The agency evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 182-501-0169.

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

(a) Alcohol and substance misuse counseling (refer to WAC 182-531-1710);

(b) Allergen immunotherapy services;

((~~(b)~~)) (c) Anesthesia services;

((~~(c)~~)) (d) Dialysis and end stage renal disease services (refer to chapter 182-540 WAC);

((~~(d)~~)) (e) Emergency physician services;

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

((~~(f)~~)) (g) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 182-534-0100);

((~~(g)~~)) (h) Habilitative services (refer to WAC 182-545-400);

(i) Reproductive health services (refer to chapter 182-532 WAC);

((~~(h)~~)) (j) Hospital inpatient services (refer to chapter 182-550 WAC);

((~~(i)~~)) (k) Maternity care, delivery, and newborn care services (refer to chapter 182-533 WAC);

((~~(j)~~)) (l) Office visits;

((~~(k)~~)) (m) Vision-related services (refer to chapter 182-544 WAC for vision hardware for clients twenty years of age and younger);

((~~(l)~~)) (n) Osteopathic treatment services;

((~~(m)~~)) (o) Pathology and laboratory services;

((~~(n)~~)) (p) Physiatry and other rehabilitation services (refer to chapter 182-550 WAC);

((~~(o)~~)) (q) Foot care and podiatry services (refer to WAC 182-531-1300);

((~~(p)~~)) (r) Primary care services;

((~~(q)~~)) (s) Psychiatric services((~~, provided by a psychiatrist~~));

((~~(r)~~)) (t) Psychotherapy services ((~~for children as provided in~~)), WAC 182-531-1400;

((~~(s)~~)) (u) Pulmonary and respiratory services;

((~~(t)~~)) (v) Radiology services;

((~~(u)~~)) (w) Surgical services;

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

~~(w) Oral health care services for emergency conditions for clients twenty-one years of age and older, except for clients of the division of developmental disabilities (refer to WAC 182-531-1025); and~~

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

(y) Other outpatient physician services.

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

(a) A screening exam covered by the EPSDT program (see WAC 182-534-0100);

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

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

(6) By providing covered services to a client eligible for a medical assistance program, a provider who meets the requirements in WAC 182-502-0005(3) accepts the agency's rules and fees which includes federal and state law and regulations, billing instructions, and ((~~agency issuances~~)) provider notices.

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-531-0150 Noncovered physician-related and health care professional services—General and administrative. (1) Except as provided in WAC 182-531-0100 and subsection (2) of this section, the medicaid agency does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

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

(d) Hysterectomy performed solely for the purpose of sterilization;

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

(f) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 182-501-0165;

(g) Hair transplantation;

(h) Marital counseling or sex therapy;

(i) More costly services when the medicaid agency determines that less costly, equally effective services are available;

(j) Vision-related services as follows:

(i) Services for cosmetic purposes only;

(ii) Group vision screening for eyeglasses; and

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

(k) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 182-531-1750;

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

(m) Physical examinations or routine checkups, except as provided in WAC 182-531-0100;

(n) Foot care, unless the client meets criteria and conditions outlined in WAC 182-531-1300, as follows:

(i) Routine foot care, such as but not limited to:

(A) Treatment of tinea pedis;

(B) Cutting or removing warts, corns and calluses; and

(C) Trimming, cutting, clipping, or debriding of nails.

(ii) Nonroutine foot care, such as, but not limited to treatment of:

(A) Flat feet;

(B) High arches (cavus foot);

(C) Onychomycosis;

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

(E) Hallux malleus;

(F) Equinus deformity of foot, acquired;

(G) Cavovarus deformity, acquired;

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

(I) Hallux limitus.

(iii) Any other service performed in the absence of localized illness, injury, or symptoms involving the foot;

(o) Except as provided in WAC 182-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services((~~.~~));

(p) Nonmedical equipment;

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

(r) Bilateral cochlear implantation((~~; and~~

~~(s) Routine or nonemergency medical and surgical dental services provided by a doctor of dental medicine or dental surgery for clients twenty-one years of age and older, except for clients of the developmental disabilities administration in the department of social and health services~~)).

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

(a) The EPSDT program;

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

(c) A waiver program.

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

WAC 182-531-0250 Who can provide and bill for physician-related and health care professional services. (((~~(1) The following enrolled providers are eligible to provide and bill for physician-related and health care professional services which they provide to eligible clients:~~

~~(a) Advanced registered nurse practitioners (ARNP);~~

~~(b) Federally qualified health centers (FQHCs);~~

~~(c) Health departments;~~

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

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

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

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

~~(h) Licensed radiology facilities;~~

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

~~(j) Medicare-certified ambulatory surgery centers;~~

~~(k) Medicare-certified rural health clinics;~~

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

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

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

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

~~(ii) Medicine and osteopathy;~~

~~(iii) Nursing;~~

~~(iv) Optometry; or~~

~~(v) Podiatry.~~)) (1) The health care professionals and health care entities listed in WAC 182-502-0002 and enrolled with the agency can bill for physician-related and health care professional services that are within their scope of practice.

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

~~(a) Acupuncturists;~~

~~(b) Christian Science practitioners or theological healers;~~

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

~~(d) Herbalists;~~

~~(e) Homeopaths;~~

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

~~(g) Naturopaths;~~

~~(h) Sanipractors;~~

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

~~(i) Are employed by an FQHC;~~

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

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

~~(j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0002; or~~

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

~~(i) Licensed to provide; and~~

~~(ii) Trained to provide~~)) health care professionals listed in WAC 182-502-0003.

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

(a) The EPSDT program;

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

(c) A waiver program.

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

WAC 182-531-0800 Laboratory and pathology physician-related services. (1) The ((~~department~~)) medicaid agency reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) The ((~~department~~)) agency includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) The ((~~department~~)) agency reimburses only one blood drawing fee per client, per day. The ((~~department~~)) agency allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) The ((~~department~~)) agency reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) The ((~~department~~)) agency reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, the ((~~department~~)) agency reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) The ((~~department~~)) agency allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) The ((~~department~~)) agency reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) The ((~~department~~)) agency reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) The ((~~department~~)) agency does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) The ((~~department~~)) agency does not cover for drug screens to monitor ((~~any of the following:~~

~~(a)~~)) for program compliance in either a residential or outpatient drug or alcohol treatment program((~~;~~

~~(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or~~

~~(c) Suspected drug use by clients in a residential setting, such as a group home~~)).

(10) The ((~~department~~)) agency may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill the ((~~department~~)) agency directly. The ((~~department~~)) agency does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

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

WAC 182-531-1050 Osteopathic manipulative treatment. (1) The ((~~department reimburses~~)) medicaid agency pays for osteopathic manipulative therapy (OMT) only when ((~~OMT is~~)):

(a) Provided by an osteopathic physician licensed under chapter 18.71 RCW((~~.~~

~~(2) The department reimburses OMT only when the provider bills~~)) or naturopathic physicians licensed under chapter 246-836 WAC; and

(b) Billed using the appropriate CPT codes that involve the number of body regions involved.

(((~~(3)~~))) (2) The ((~~department~~)) agency allows an osteopathic physician or naturopathic physician to bill the ((~~department~~)) agency for an evaluation and management (E&M) service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(((~~(4)~~))) (3) The ((~~department~~)) agency limits ((~~reimbursement~~)) payment for manipulations to ten per client, per calendar year. ((~~Reimbursement~~)) Payment for each manipulation includes a brief evaluation as well as the manipulation.

(((~~(5)~~))) (4) The ((~~department~~)) agency does not ((~~reimburse~~)) pay for physical therapy services performed by osteopathic physicians or naturopathic physicians.

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

WAC 182-531-1400 Psychiatric physician-related services and other professional mental health services. (((~~(1) The mental health services covered in the medical benefits described in this section are separate from the mental health services covered by the mental health managed care system administered under the authority of the mental health division pursuant to chapter 388-865 WAC. The department covers outpatient mental health services with the following limitations:~~

~~(a) For clients eighteen years of age and younger:~~

~~(i) The department pays for only one hour per day, per client, up to a total of twenty hours per calendar year, including the psychiatric diagnostic evaluation and family therapy visits that are medically necessary to the client's treatment;~~

~~(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric advanced registered nurse practitioners (ARNP) in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and~~

~~(iii) The mental health services must be provided in an outpatient setting by a psychiatrist, psychologist, psychiatric ARNP, social worker, marriage and family therapist, or mental health counselor who must:~~

~~(A) Be licensed, in good standing and without restriction, by the department of health under their appropriate licensure; and~~

~~(B) Have a minimum of two years experience in the diagnosis and treatment of clients eighteen years of age and younger and their families, including a minimum one year under the supervision of a mental health professional trained in child and family mental health. A licensed psychiatrist may provide these services and bill the department without meeting this requirement.~~

~~(b) For clients nineteen years of age and older:~~

~~(i) The department pays for only one hour per day, per client, up to a total of twelve hours per calendar year, including family or group therapy visits;~~

~~(ii) The department limits medication management services to one per day, but this service may be billed by psychiatrists and psychiatric ARNPs in conjunction with the diagnostic interview examination, or when a psychiatrist or psychiatric ARNP performs medication management services on the same day as a different licensed mental health practitioner renders another billable mental health service; and~~

~~(iii) The mental health services must be provided by a psychiatrist in an outpatient setting.~~

~~(2) The department covers inpatient mental health services with the following limitations:~~

~~(a) Must be provided by a psychiatrist;~~

~~(b) Only the total time spent on direct psychiatric client care during each visit; and~~

~~(c) One hospital call per day for direct psychiatric client care, including making rounds. Making rounds is considered direct client care and includes any one of the following:~~

~~(i) Individual psychotherapy up to one hour;~~

~~(ii) Family/group therapy; or~~

~~(iii) Electroconvulsive therapy.~~

~~(3) With the exception of medication management, the department covers other mental health services described in this section with the limitation of one per client, per day regardless of location or provider type.~~

~~(4) The department pays psychiatrists when the client receives a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.~~

~~(5) The department covers psychiatric diagnostic interview evaluations at the limit of one per provider, per calendar~~

~~year unless a significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the department.~~

~~(6) The department does not cover psychiatric sleep therapy.~~

~~(7) The department covers electroconvulsive therapy and narcosynthesis only when performed by a psychiatrist.~~

~~(8) The department pays psychiatric ARNPs only for mental health medication management and diagnostic interview evaluations provided to clients nineteen years of age and older.~~

~~(9) The department covers interactive, face-to-face visits at the limit of one per client, per day, in an outpatient setting. Interactive, face-to-face visits may be billed only for clients age twenty and younger.~~

~~(10) The client or licensed health care provider may request a limitation extension only when the client exceeds the total hour limit described in subsection (1) of this section, and for no other limitation of service in this section. The department will evaluate these requests in accordance with WAC 388-501-0169.~~

~~(11) DSHS providers must comply with chapter 388-865 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the mental health division or the appropriate regional support network (RSN).~~

~~(12) Accepting payment under more than one contract or agreement with the department for the same service for the same client constitutes duplication of payment. If a client is provided services under multiple contracts or agreements, each provider must maintain documentation identifying the type of service provided and the contract or agreement under which it is provided to ensure it is not a duplication of service.~~)) (1) The mental health services covered in this section are different from the mental health services covered under chapter 388-865 WAC, community mental health and involuntary treatment programs administered by the department of social and health services' division of behavioral health and recovery.

(2) The medicaid agency covers professional inpatient and outpatient mental health services not covered under chapter 388-865 WAC according to this section.

Inpatient mental health services

(3) For hospital inpatient psychiatric admissions, providers must comply with the department of social and health services (DSHS) rules in chapter 388-865 WAC, Community mental health and involuntary treatment programs.

(4) The agency covers professional inpatient mental health services as follows:

(a) When provided by a psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), or psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(b) One hospital call per day for direct psychiatric client care. The agency pays only for the total time spent on direct psychiatric client care during each visit, including services rendered when making rounds. The agency considers services rendered during rounds to be direct client care services and may include, but are not limited to:

(i) Individual psychotherapy up to one hour;

(ii) Family/group therapy; or

(iii) Electroconvulsive therapy.

(c) One electroconvulsive therapy or narcosynthesis per client, per day when performed by a psychiatrist only.

Outpatient mental health services

(5) The agency covers outpatient mental health services when provided by the following licensed health care professionals in good standing with the agency and who are without restriction by the department of health under their appropriate licensure:

(a) Psychiatrist;

(b) Psychologists;

(c) Psychiatric advanced registered nurse practitioner (ARNP) or psychiatric mental health nurse practitioner-board certified (PMHNP-BC);

(d) Mental health counselors;

(e) Independent clinical social workers;

(f) Advanced social workers; or

(g) Marriage and family therapists.

(6) With the exception of licensed psychiatrists, qualified health care professionals who treat clients eighteen years of age and younger must have a minimum of two years' experience in the diagnosis and treatment of clients eighteen years of age and younger, including one year of supervision by a mental health professional trained in child and family mental health.

(7) The agency does not limit the total number of outpatient mental health visits the licensed health care professional can provide.

(8) The agency covers outpatient mental health services with the following limitations, subject to the provision of WAC 182-501-0169:

(a) One psychiatric diagnostic evaluation, per provider, per client, per calendar year, unless significant change in the client's circumstances renders an additional evaluation medically necessary and is authorized by the agency.

(b) One individual or family/group psychotherapy visit, with or without the client, per day, per client, per calendar year.

(c) One psychiatric medication management service, per client, per day, in an outpatient setting when performed by one of the following:

(i) Psychiatrist;

(ii) Psychiatric advanced registered nurse practitioner (ARNP); or

(iii) Psychiatric mental health nurse practitioner-board certified (PMHNP-BC).

(9) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for outpatient mental health services when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

(10) The agency requires the appropriate place of service for mental health services. If the client meets the regional support network (RSN) access to care standards, or subsequent standards, the client must be referred to the RSN for an assessment and possible treatment.

(11) If during treatment there is an indication that the client meets the RSN access to care standards, an assessment

must be conducted. This assessment may be completed by either a health care professional listed in subsection (5) of this section or a representative of the RSN.

(12) To support continuity of care, the client may continue under the care of the provider until an RSN can receive the client.

(13) After the client completes fifteen mental health visits under this benefit, the provider must submit to the agency a written attestation that the client has been assessed for meeting access to care standards.

(14) To be paid for providing mental health services, providers must bill the agency using the agency's current published billing instructions.

(15) The agency considers acceptance of multiple payments for the same client for the same service on the same date to be a duplication of payment. Duplicative payments may be recouped by the agency under WAC 182-502-0230. To prevent duplicative payments, providers must keep documentation identifying the type of service provided and the contract or agreement under which it is provided.

NEW SECTION

WAC 182-531-1710 Alcohol and substance misuse counseling. (1) The medicaid agency covers alcohol and substance misuse counseling through screening, brief intervention, and referral to treatment (SBIRT) services when delivered by, or under the supervision of, a qualified licensed physician or other qualified licensed health care professional within the scope of their practice.

(2) SBIRT is a comprehensive, evidence-based public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community health care settings: Primary care centers, hospital emergency rooms, and trauma centers.

(3) The following health care professionals are eligible to become qualified SBIRT providers to deliver SBIRT services or supervise qualified staff to deliver SBIRT services:

(a) Advanced registered nurse practitioners, in accordance with chapters 18.79 RCW and 246-840 WAC;

(b) Chemical dependency professionals, in accordance with chapters 18.205 RCW and 246-811 WAC;

(c) Licensed practical nurse, in accordance with chapters 18.79 RCW and 246-840 WAC;

(d) Mental health counselor, in accordance with chapters 18.225 RCW and 246-809 WAC;

(e) Marriage and family therapist, in accordance with chapters 18.225 RCW and 246-809 WAC;

(f) Independent and advanced social worker, in accordance with chapters 18.225 RCW and 246-809 WAC;

(g) Physician, in accordance with chapters 18.71 RCW and 246-919 WAC;

(h) Physician assistant, in accordance with chapters 18.71A RCW and 246-918 WAC;

(i) Psychologist, in accordance with chapters 18.83 RCW and 246-924 WAC;

(j) Registered nurse, in accordance with chapters 18.79 RCW and 246-840 WAC;

(k) Dentist, in accordance with chapters 18.260 and 246-817; and

(l) Dental hygienists, in accordance with chapters 18.29 and 246-815 WAC.

(4) To qualify as a qualified SBIRT provider, eligible licensed health care professionals must:

(a) Complete a minimum of four hours of SBIRT training; and

(b) Mail or fax the SBIRT training certificate or other proof of training completion to the agency.

(5) The agency pays for SBIRT as follows:

(a) Screenings, which are included in the reimbursement for the evaluation and management code billed;

(b) Brief interventions, limited to four sessions per client, per provider, per calendar year; and

(c) When billed by one of the following qualified SBIRT health care professionals:

(i) Advanced registered nurse practitioners;

(ii) Mental health counselors;

(iii) Marriage and family therapists;

(iv) Independent and advanced social workers;

(v) Physicians;

(vi) Psychologists;

(vii) Dentists; and

(viii) Dental hygienists.

(6) To be paid for providing alcohol and substance misuse counseling through SBIRT, providers must bill the agency using the agency's current published billing instructions.

NEW SECTION

WAC 182-531-1720 Tobacco cessation counseling. (1) The medicaid agency covers tobacco cessation services when delivered by qualified providers through the agency contracted quitline or face-to-face office visits for tobacco cessation for pregnant clients.

(2) The agency pays for face-to-face office visits for tobacco cessation counseling for pregnant clients with the following limits:

(a) When provided by physicians, advanced registered nurse practitioners (ARNPs), physician assistants-certified (PA-Cs), naturopathic physicians, and dentists;

(b) Two cessation counseling attempts (or up to eight sessions) are allowed every twelve months. An attempt is defined as up to four cessation counseling sessions.

(3) To be paid for tobacco cessation counseling through SBIRT, providers must bill the agency using the agency's current published billing instructions.

NEW SECTION

WAC 182-531-1730 Telemedicine. (1) Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows clients,

particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

(2) The medicaid agency does not cover the following services as telemedicine:

(a) E-mail, telephone, and facsimile transmissions;

(b) Installation or maintenance of any telecommunication devices or systems; and

(c) Purchase, rental, or repair of telemedicine equipment.

(3) **Originating site.** An originating site is the physical location of the client at the time the health care service is provided. The agency pays the originating site a facility fee per completed transmission. Approved originating sites are:

(a) Clinics;

(b) Community settings;

(c) Homes;

(d) Hospitals – Inpatient and outpatient; and

(e) Offices.

(4) **Distance site.** A distant site is the physical location of the health care professional providing the health care service.

(5) Program-specific policies regarding the coverage of telemedicine can be found in the agency's billing instructions.

(6) To be paid for providing health care services via telemedicine, providers must bill the agency using the agency's current published billing instructions.

(7) If a health care professional performs a separately identifiable service for the client on the same day as the telemedicine service, documentation for both services must be clearly and separately identified in the client's medical record.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-531-1025	Oral health care services provided by dentists for clients age twenty-one and older—General.

WSR 14-02-079
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:47 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The health care authority must implement federal requirements under the Affordable Care Act and changes under the legislative session of 2013 concerning eligibility for TAKE CHARGE in accordance with the federal waiver amendments.

Citation of Existing Rules Affected by this Order: Amending WAC 182-532-720.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148); RCW 41.05.021; and 3ESSB 5034, section 213(29), chapter 4, Laws of 2013.

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: This rule is necessary to update eligibility criteria for TAKE CHARGE to comply with changes under the legislative session of 2013 and in federal law that take effect January 1, 2014.

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

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 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 30, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-720 TAKE CHARGE program—Eligibility. (1) The TAKE CHARGE program is for men and women. To be eligible for the TAKE CHARGE program, an applicant must:

(a) Be a United States citizen, U.S. National, or "qualified alien" as described in WAC 182-503-0530, and give proof of citizenship or qualified alien status and identity upon request from the medicaid agency;

(b) Provide a valid Social Security number (SSN);

(c) Be a resident of the state of Washington as described in WAC 388-468-0005;

(d) Have an income at or below two hundred ((~~fifty~~)) sixty percent of the federal poverty level as described in WAC 182-505-0100;

(e) Need family planning services;

(f) Have applied for and been denied full-scope medicaid coverage by the agency;

(g) Apply voluntarily for family planning services with a TAKE CHARGE provider; and

((~~(g)~~)) (h) Not be covered currently through another medical assistance program for family planning.

(2) ((~~A client~~)) An applicant who is pregnant or sterilized is not eligible for TAKE CHARGE.

(3) An applicant who has concurrent coverage under a creditable health insurance policy is not eligible for TAKE CHARGE unless the applicant is a minor seeking confidential services.

(4) A client is authorized for TAKE CHARGE coverage for one year from the date the medicaid agency determines eligi-

bility. Upon reapplication for TAKE CHARGE by the client, the medicaid agency may renew the coverage for an additional period of up to one year, or for the duration of the waiver, whichever is shorter.

WSR 14-02-080
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:47 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: Restore adult dental benefit for eligible clients beginning January 1, 2014.

Citation of Existing Rules Affected by this Order: Amending WAC 182-535-1060.

Statutory Authority for Adoption: RCW 41.05.021; 3ESSB 5034 (section 213, chapter 4, Laws of 2013).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, 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: These emergency rules are necessary to meet the requirements in 3ESSB 5034, section 213, chapter 4, Laws of 2013, 63rd legislature, effective January 1, 2014.

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

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

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

Date Adopted: December 31, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-09-081, filed 4/17/12, effective 5/18/12)

WAC 182-535-1060 Clients who are eligible for dental-related services. (1) ((~~The clients described in this section are eligible to receive the dental-related services described in this chapter, 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:~~

~~(i) Categorically needy (CN);~~

~~(ii) Children's health care as described in WAC 388-505-0210;~~

~~(iii) Medically needy (MN);~~

~~(iv) Medical care services (MCS) as described in WAC 182-508-0005;~~

~~(v) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).~~

~~(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 an agency-contracted managed care 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 and other applicable 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); or~~

~~(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.~~)) Refer to WAC 182-501-0060 to see which Washington apple health programs include dental-related services in their benefit package.

(2) Managed care clients are eligible under Washington apple health fee-for-service for covered dental-related services not covered by their MCO plan, subject to the provisions of this chapter and other applicable agency rules.

(3) See WAC ((~~388-438-0120~~)) 182-507-0115 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 eligible for comprehensive dental services as described in subsection (1) of this section. Clients who do not have these dental services in their benefit package may be eligible only for the emergency oral health care benefit according to WAC 182-531-1025.~~))

(4) Exception to rule procedures as described in WAC 182-501-0169 are not available for services that are excluded from a client's benefit package.

NEW SECTION

WAC 182-535-1066 Dental-related services—Medical care services clients. (1) The agency covers the following dental-related services for a medical care services client as listed in WAC 182-501-0060 when the services are provided by a dentist to assess and treat pain, infection, or trauma of the mouth, jaw, or teeth, including treatment of post-surgical complications, such as dry socket:

(a) Limited oral evaluation;

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

(c) Palliative treatment to relieve dental pain;

(d) Pulpal debridement to relieve dental pain; and

(e) Tooth extraction.

(2) Tooth extractions require prior authorization when:

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

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

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

WSR 14-02-081
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:48 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: These rules are necessary to establish a separate recognition for individually configured, complex rehabilitation technology (CRT) products and services for complex medical-need clients in the medical assistance program.

Citation of Existing Rules Affected by this Order: Amending WAC 182-543-0500, 182-543-1000, 182-543-1100, 182-543-2000, 182-543-2100, 182-543-2200, 182-543-2250, 182-543-3000, 182-543-3100, 182-543-3200, 182-543-3300, 182-543-3400, 182-543-3500, 182-543-4000, 182-543-4100, 182-543-4200, 182-543-4300, 182-543-5000, 182-543-5700, 182-543-6000, 182-543-7000, 182-543-7100, 182-543-7200, 182-543-7300, 182-543-8000, 182-543-8100, 182-543-8200, 182-543-9000, and 182-543-9200.

Statutory Authority for Adoption: RCW 41.05.021; E2SHB 1445, chapter 178, Laws of 2013, 63rd legislature, 2013 regular session.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, 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: These emergency rules are necessary to meet the requirements in E2SHB 1445, chapter 178, Laws of 2013, 63rd legislature, 2013 regular session, effective January 1, 2014.

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 2, Amended 29, 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 2, Amended 29, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

Chapter 182-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, COMPLEX REHABILITATION TECHNOLOGY, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

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

WAC 182-543-0500 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—General. (1) The federal government considers durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, and medical supplies as optional services under the medicaid program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The ((~~department~~)) medicaid agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

(2) The ((~~department~~)) agency covers the DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and

medical supplies listed in this chapter, according to ((~~department~~)) agency rules and subject to the limitations and requirements in this chapter.

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

(a) Covered;

(b) Within the scope of the client's medical program (see WAC ((~~388-501-0060 and 388-501-0065~~)) 182-501-0060 and 182-501-0065);

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

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

(e) Authorized, as required within this chapter, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, and the ((~~department's~~)) agency's published billing instructions and ((~~numbered memoranda~~)) provider notices;

(f) Billed according to this chapter, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, and the ((~~department's~~)) agency's published billing instructions and ((~~numbered memorandum~~)) provider notices; and

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

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

(a) The ((~~department~~)) agency evaluates requests requiring prior authorization on a case-by-case basis to determine medical necessity, according to the process found in WAC ((~~388-501-0165~~)) 182-501-0165.

(b) Refer to WAC ((~~388-543-7000, 388-543-7001, and 388-543-7003~~)) 182-543-7000, 182-543-7001, and 182-543-7003 for specific details regarding authorization.

(5) The ((~~department~~)) agency bases its determination about which DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC ((~~388-543-7100~~)) 182-543-7100 for PA and WAC ((~~388-543-7300~~)) 182-543-7300 for EPA). The ((~~department~~)) agency considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(6) The ((~~department~~)) agency evaluates a request for any ((~~DME~~)) item listed as noncovered in this chapter under the provisions of WAC ((~~388-501-0160~~)) 182-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the ((~~department~~)) agency evaluates a noncovered service, equipment, or supply according to the process in WAC ((~~388-501-0165~~)) 182-502-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC ((~~388-543-0100~~)) 182-543-0100 for EPSDT rules).

(7) The ((~~department~~)) agency may terminate a provider's participation with the ((~~department~~)) agency according to WAC ((~~388-502-0030 and 388-502-0040~~)) 182-502-0030 and 182-502-0040.

(8) The ((~~department~~)) agency evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under the provisions of WAC ((~~388-501-0165~~)) 182-501-0165.

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

WAC 182-543-1000 DME and related supplies, complex rehabilitation technology, prosthetics, and orthotics, medical supplies and related services—Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC ((~~388-500-0005~~)) apply to this chapter.

"By-report (BR)" ((~~A method of payment in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. The provider must submit a report which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.~~)) - See WAC 182-500-0015.

"Complex needs patient" - An individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology (CRT)" - Means wheelchairs and seating systems classified as durable medical equipment within the medicare program that:

(1) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

(2) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(3) Require certain services to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting and configuration.

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

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

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

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

(1) Can withstand repeated use;

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

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

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

"EPSDT" - See WAC ((~~388-500-0005~~)) 182-500-0030.

"Expedited prior authorization (EPA)" - ((~~The process for obtaining authorization for selected health care services in which providers use a set of numeric codes to indicate to the department which acceptable indications, conditions, or department-defined criteria are applicable to a particular request for authorization. EPA is a form of prior authorization.~~)) See WAC 182-500-0030.

"Fee-for-service (FFS)" - ((~~The general payment method the department uses to pay for covered medical services provided to clients, except those services covered under the department's prepaid managed care programs.~~)) See WAC 182-500-0035.

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

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

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

"Individually configured" – A device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

"Limitation extension" - A client-specific authorization by the ((~~department~~)) agency for additional covered services beyond the set amount allowed under ((~~department~~)) agency rules. See WAC ((~~388-501-0169~~)) 182-501-0169.

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

"Medical supplies" - Supplies that are:

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

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

"Medically necessary" - See WAC ((~~388-500-0005~~)) 182-500-0070.

"National provider indicator (NPI)" - ((~~A federal system for uniquely identifying all providers of health care services, supplies, and equipment.~~)) See WAC 182-500-0075.

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

"Orthotic device" or **"orthotic" -** A corrective or supportive device that:

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

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

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

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

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

"Prior authorization" - ((~~The requirement that a provider must request, on behalf of a client and when required by rule, the department's approval to render a health care service or write a prescription in advance of the client receiving the health care service or prescribed drug, device, or drug-related supply. The department's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.~~)) See WAC 182-500-0085.

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

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

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

~~(3) Support a weak or deformed portion of the body.~~)) See WAC 182-500-0085.

"Qualified complex rehabilitation technology supplier" - A company or entity that:

(1) Is accredited by a recognized accrediting organization as a supplier of CRT;

(2) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

(3) For each site that it operates, employs at least one CRT professional, who has been certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities, and provide training in the use of the selected covered CRT items;

(4) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured complex rehabilitation technologies for the complex needs patient;

(5) Provides service and repairs by qualified technicians for all complex rehabilitation technology products it sells; and

(6) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair.

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

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

"Scooter" - A federally approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

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

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

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

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

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

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

"Usual and customary charge" - ((~~The amount the provider typically charges to fifty percent or more of his or her patients who are not medical assistance clients.~~)) See WAC 182-500-0110.

"Warranty-period" - A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

"Wheelchair - Manual" - A federally approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(1) Standard:

(a) Usually is not capable of being modified;

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

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

(2) Lightweight:

(a) Composed of lightweight materials;

(b) Capable of being modified;

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

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

(3) High-strength lightweight:

(a) Is usually made of a composite material;

(b) Is capable of being modified;

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

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

(e) Accommodates the very active person.

(4) Hemi:

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

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

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

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

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

(8) Heavy duty:

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

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

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

(10) Custom heavy duty:

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

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

(11) Custom manufactured specially built:

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

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

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

(1) Custom power adaptable to:

(a) Alternative driving controls; and

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

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

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

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

WAC 182-543-1100 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Client eligibility. (1) ((~~Durable medical equipment (DME) and related services, prosthetics and orthotics, medical supplies and related services are available to clients who are eligible for services under one of the following medical assistance programs:~~

~~(a) Categorically needy (CN);~~

~~(b) Children's health care as described in WAC 388-505-0210;~~

~~(c) Medically needy (MN);~~

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

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

~~(2)~~)) Refer to the table in WAC 182-501-0060 to see which Washington apple health (WAH) programs include DME and related services, complex rehabilitation technology (CRT), prosthetics and orthotics, medical supplies and related services in their benefit package.

(2) For clients eligible under an alien emergency medical (AEM) program, see WAC 182-507-0115.

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

(((~~(3)~~))) (4) Clients who are enrolled in a ((~~department contracted~~)) agency-contracted managed care organization (MCO) must arrange for DME and related services, prosthetics and orthotics, medical supplies and related services directly through his or her ((~~department-contracted~~)) agency-contracted MCO. The ((~~department~~)) agency does not pay for medical equipment and/or services provided to a client who is enrolled in a ((~~department-contracted~~)) agency-contracted MCO, but chose not to use one of the MCO's participating providers.

(((~~(4)~~))) (5) For clients who reside in a skilled nursing facility, see WAC ((~~388-543-5700~~)) 182-543-5700.

(6) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related equipment when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

AMENDATORY SECTION (Amending WSR 12-15-015, filed 7/10/12, effective 9/1/12)

WAC 182-543-2000 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service basis as follows:

(a) DME providers who are enrolled with medicare for DME and related repair services;

(b) Qualified CRT suppliers who are enrolled with medicare for DME and related repair services;

(c) Medical equipment dealers who are enrolled with medicare, pharmacies who are enrolled with medicare, and home health agencies under their national provider indicator (NPI) for medical supplies;

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

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

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

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

(a) Meet the general provider requirements in chapter 182-502 WAC;

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

(c) Have a valid prescription;

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (13-794). The agency's electronic forms are available online at: ((~~http://hrsa.dshs.wa.gov/mpforms.shtml~~)) http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx;

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

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

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

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

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

(d) Provide instructions for use of equipment;

(e) Furnish only new equipment to clients that includes full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Furnish documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

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

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

WAC 182-543-2100 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Requests to include new equipment/supplies/technology. (1) An interested party may request the ((~~department~~)) medicaid agency to include new equipment/supplies in the ((~~department's~~))

agency's durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related services billing instructions.

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

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

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

(d) Proof of certification from the Centers for Medicare and Medicaid Services (CMS), if applicable; and

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

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

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

WAC 182-543-2200 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Proof of delivery. (1) When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the ((~~department~~)) medicaid agency requests that information. All of the following apply:

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

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

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

(iii) For durable medical equipment (DME) and complex rehabilitation technology (CRT) that may require future repairs, include the serial number.

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

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

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

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

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

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

(ii) The delivery service package identification number; and

(iii) The delivery address.

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

(i) The client's name;

(ii) The shipping service package identification number;

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

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

(c) When billing the ((~~department~~)) agency:

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

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

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

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

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

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

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

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

WAC 182-543-2250 DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—Rental or purchase. (1) The ((~~department~~)) medicaid agency bases its decision to rent or purchase durable medical equipment (DME) on the length of time the client needs the equipment.

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

(3) The ((~~department~~)) agency purchases new DME equipment and complex rehabilitation technology (CRT) only.

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

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

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

(a) In good working order; and

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

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

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

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

(a) Delivery to the client;

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

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

(d) Return pickup by the provider.

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

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

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

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

(b) Electric hospital-grade breast pumps.

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

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

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

(b) Medicare considers the equipment purchased.

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

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

WAC 182-543-3000 Covered—Hospital beds, mattresses, and related equipment. (1) Hospital beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Does not also have a rental wheelchair.

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

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

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

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

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

(E) Does not have a rental wheelchair.

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

(i) The client:

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

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

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

(D) Is diagnosed:

(I) With quadriplegia;

(II) With tetraplegia;

(III) With duchenne muscular dystrophy;

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

(V) As ventilator-dependent; or

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

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

(A) A completed General Information for Authorization form (((~~DSHS~~)) HCA 13-835) and Hospital Bed Evaluation form (((~~DSHS~~)) HCA 13-747). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization);

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards. The ((~~department~~)) medicaid agency covers the purchase of the following with the stated limitations, without prior authorization:

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

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

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

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

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

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

WAC 182-543-3200 Covered—Positioning devices. The ((~~department~~)) medicaid agency covers, without prior authorization, positioning devices with the following limitations:

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

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

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

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

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

WAC 182-543-3300 Covered—Osteogenesis electrical stimulator (bone growth stimulator). (1) The ((~~department~~)) medicaid agency covers, with prior authorization, noninvasive osteogenesis electrical stimulators, limited to one per client, in a five-year period.

(2) The ((~~department~~)) agency pays for the purchase of nonspinal bone growth stimulators, only when:

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

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

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

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

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

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

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

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

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

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

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

WAC 182-543-3400 Covered—Communication devices/speech generating devices (SGD). (1) The ((~~department~~)) medicaid agency covers:

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

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

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

(a) Digitized speech output, using prerecorded messages;

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

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

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

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

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

(i) A completed General Information for Authorization form (((~~DSHS~~)) HCA 13-835). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization); and

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

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

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

(C) Documentation of all of the following:

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

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

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

(iii) A copy of the prescription for the SGD from the client's treating physician written on a ((~~department~~)) agency Prescription Form (((~~DSHS~~)) 13-794) (see WAC ((~~388-543-2000~~)) 182-543-2000(2)).

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

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

(a) All warranties are expired;

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

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

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

(7) The ((~~department~~)) agency pays for replacement batteries for a SGD in accordance with WAC ((~~388-543-5500~~)) 182-543-5500(3). The ((~~department~~)) agency does not pay for back-up batteries for a SGD.

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

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

WAC 182-543-3500 Covered—Ambulatory aids (canes, crutches, walkers, related supplies). (1) The ((~~department~~)) medicaid agency covers the purchase of the following ambulatory aids with stated limitations, without prior authorization:

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

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

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

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

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

WAC 182-543-4000 Covered—Wheelchairs—General. (1) The ((~~department~~)) medicaid agency covers, with prior authorization, manual and power-drive wheelchairs for clients who reside at home. For clients who reside in a skilled nursing facility, see WAC ((~~388-543-5700~~)) 182-543-5700.

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

(a) General Information for Authorization form (((~~DSHS~~)) HCA 13-835). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization);

(b) A Prescription Form (((~~DSHS~~)) 13-794); and

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

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

(4) When the ((~~department~~)) agency determines that a wheelchair is medically necessary, according to the process found in WAC ((~~388-501-0165~~)) 182-501-0165, for six

months or less, the ((~~department~~)) agency rents a wheelchair for clients who live at home. For clients who reside in a skilled nursing facility, see WAC ((~~388-543-5700~~)) 182-543-5700.

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

WAC 182-543-4100 Covered—Wheelchairs—Manual. The ((~~department~~)) medicaid agency covers the rental or purchase of a manual wheelchair for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. For clients who reside in a skilled nursing facility, see WAC ((~~388-543-5700~~)) 182-543-5700.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) A rigid wheelchair for a client:

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

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

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

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

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

(2) The ((~~department~~)) agency pays for both a manual wheelchair and a power-drive wheelchair only for noninstitutionalized clients in limited circumstances. See WAC ((~~388-543-4200~~)) 182-543-4200(5).

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

WAC 182-543-4200 Covered—Wheelchairs—Power-drive. (1) The ((~~department~~)) medicaid agency covers power-drive wheelchairs when the prescribing physician certifies that the following clinical criteria are met:

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

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

(c) A power-drive wheelchair will:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs. (1) The ((~~department~~)) agency covers, with prior authorization, wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. To receive payment, providers must submit the following to the ((~~department~~)) agency:

(a) A completed General Information for Authorization form (((~~DSHS~~)) HCA 13-835). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization);

(b) A completed Prescription Form (((~~DSHS~~)) 13-794);

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

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

(e) The modification requested; and

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

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

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

(a) General Information for Authorization form (((~~DSHS~~)) HCA 13-835). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000);

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

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

(d) The repair requested.

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

NEW SECTION

WAC 182-543-4400 Covered—Complex rehabilitation technology. (1) The agency covers, with prior authorization, individually configured, complex rehabilitation technology (CRT) products.

(2) CRT must be supplied by a CRT supplier with the appropriate taxonomy number to bill for the items.

(3) Each site that a company operates must employ at least one CRT professional, who has been certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(4) The client must be evaluated by a licensed health care provider who performs specialty evaluations with their scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.

(a) At the evaluation, a CRT professional must also be present from the company ordering the equipment; or

(b) The CRT provider must be present at the evaluation to:

(i) Assist in selection of the appropriate CRT item(s); and

(ii) Provide training in the use of the selected items.

(5) The CRT provider must:

(a) Provide service and repairs by qualified technicians for all CRT products it sells; and

(b) Provide written information to the client at the time of delivery as to how the client may receive services and repairs.

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

WAC 182-543-5000 Covered—Prosthetics/orthotics. (1) The ((~~department~~)) agency covers, without prior authorization, the following prosthetics and orthotics, with stated limitations:

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

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

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

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

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

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

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

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

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

(3) The ((~~department~~)) agency pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC ((~~388-543-1000~~)) 182-543-1000 and are prescribed per WAC ((~~388-543-1100 and 388-543-1200~~)) 182-543-1100 and 182-543-1200.

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

(a) All warranties are expired;

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

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

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

(6) For prosthetics dispensed for purely cosmetic reasons, see WAC ((~~388-543-3800 [388-543-1300]~~)) 182-543-6000, Noncovered-DME.

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

WAC 182-543-5700 Covered—DME and related supplies and complex rehabilitation technology for clients in skilled nursing facilities. (1) The ((~~department's~~)) agency's skilled nursing facility per diem rate, established in chapters 74.46 RCW, 388-96, and 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this section.

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

(a) Manual or power-drive wheelchairs (including CRT);

(b) Speech generating devices (SGD); and

(c) Specialty beds.

(3) The ((~~department~~)) agency pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization, according to the requirements in WAC ((~~388-543-4100, 388-543-4200, and 388-543-4300~~)) 182-543-4100, 182-543-4200, and 182-543-4300. Requests for prior authorization must:

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

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

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

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

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

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

(a) A completed Prescription Form (((~~DSHS~~)) 13-794);

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (((~~DSHS~~)) 13-729). The date on this form (((~~DSHS~~)) 13-727) must not be prior to the date on the Prescription Form (((~~DSHS-~~))13-794). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization);

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

(d) The modification requested; and

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

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

(a) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (((~~DSHS~~)) 13-729). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000, Authorization);

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

(c) The repair requested.

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

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

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

(9) The ((~~department~~)) agency pays for the purchase and repair of a speech generating device (SGD), with prior authorization. The ((~~department~~)) agency pays for replacement batteries for SGDs in accordance with WAC ((~~388-543-5500~~)) 182-543-5500(3).

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

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

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

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

(12) See WAC ((~~388-543-9200~~)) 182-543-9200 for reimbursement for wheelchairs and WAC 182-543-9250 for reimbursement for CRT.

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

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to, the following:

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

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

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

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

(ii) Short term management for temporary bladder atony.

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

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

WAC 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered. The ((~~department~~)) medicaid agency pays for DME and related supplies, medical supplies and related services only when listed as covered in this chapter. The ((~~department~~)) agency evaluates a request for any durable medical equipment (DME) and related supplies, prosthetics, orthotics, and medical supplies listed as noncovered in this chapter under the provisions of WAC ((~~388-501-0160~~)) 182-501-0160. In addition to the noncovered services found in WAC ((~~388-501-0070~~)) 182-501-0070, the ((~~department~~)) agency does not cover:

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

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

(3) Hairpieces or wigs;

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

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

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

(7) Prosthetic devices dispensed for cosmetic reasons;

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

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

(b) Electrical rewiring for any reason;

(c) Elevator systems and elevators;

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

(e) Lifts or ramps for the home;

(f) Overhead ceiling track lifts;

(g) Saunas;

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

(i) Swimming pools; and

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

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

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

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

(c) Car seats for children seven years of age and younger or less than four feet nine inches tall, except for prior authorized positioning car seats under WAC ((~~388-543-3200~~)) 182-543-3200;

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

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

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

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

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

(iii) Two-way radios;

(iv) Rental of related equipment or services; and

(v) Devices requested for the purpose of education.

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

(h) Ergonomic equipment;

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

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

(k) Generators;

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

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

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

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

(p) Room fresheners/deodorizers;

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

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

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

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

(10) Blood pressure monitoring:

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

(b) Blood pressure cuff only; and

(c) Automatic blood pressure monitor.

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

(12) Functional electrical stimulation (FES) bike;

(13) Wearable defibrillators;

(14) Disinfectant spray;

(15) Periwash;

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

(a) Bath stools;

(b) Bathtub wall rail (grab bars);

(c) Bed pans;

(d) Bedside commode chair;

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

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

(g) Potty chairs;

(h) Raised toilet seat;

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

(j) Shower chairs;

(k) Shower/commode chairs;

(l) Sitz type bath or equipment;

(m) Standard and heavy duty bath chairs;

(n) Toilet rail;

(o) Transfer bench for tub or toilet;

(p) Urinal male/female.

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

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

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

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

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

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

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

(g) Diverter valves and handheld showers for bathtub;

(h) Eating/feeding utensils;

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

(j) Health club memberships;

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

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

(m) Impotence devices;

(n) Insect repellants;

(o) Massage equipment;

(p) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter ((~~388-530~~)) 182-530 WAC;

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

(r) Page turners;

(s) Radio and television;

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

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

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

(a) Attendant controls (remote control devices);

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

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

(d) Decals;

(e) Hub Lock brake;

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

(g) Lighting systems;

(h) Replacement key or extra key;

(i) Speed conversion kits; and

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

(19) New durable medical equipment, supplies, or related technology that the ((~~department~~)) agency has not evaluated for coverage. See WAC ((~~388-543-2100~~)) 182-543-2100.

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

WAC 182-543-7000 Authorization. (1) The ((~~department~~)) medicaid agency requires providers to obtain authorization for covered durable medical equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related equipments as required in this chapter, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, and in published ((~~department~~)) billing instructions and/or ((~~numbered memoranda~~)) provider notices or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the ((~~department~~)) agency as specified in the ((~~department's~~)) agency's published billing instructions (see WAC ((~~388-543-7100~~)) 182-543-7100). All requests for prior authorization must be accompanied by a completed General Information for Authorization form (((~~DSHS~~)) HCA 13-835) in addition to any program specific ((~~DSHS~~)) forms as required within this chapter. The ((~~department's~~)) agency's electronic forms are available online at: ((~~http://www.dshs.wa.gov/msa/forms/eforms.html~~)) http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(b) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the ((~~department's~~)) agency's published billing instructions. The appropriate EPA number must be used when the pro-

vider bills the ((~~department~~)) agency (see WAC ((~~388-543-7200~~)) 182-543-7200).

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

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

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

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

(6) The ((~~department~~)) agency may recoup any payment made to a provider if the ((~~department~~)) agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC ((~~388-502-0100~~)) 182-502-0100 (1)(c).

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

WAC 182-543-7100 Prior authorization. (1) The ((~~department~~)) medicaid agency requires providers to obtain prior authorization for certain items and services before delivering that item or service to the client, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. The item or service must also be delivered to the client before the provider bills the ((~~department~~)) agency.

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

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

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

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-543-7200 Limitation extension (LE). (1) The ((~~department~~)) medicaid agency limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization.

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

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

(4) The ((~~department~~)) agency evaluates such requests for LE under the provisions of WAC ((~~388-501-0169~~)) 182-501-0169.

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

WAC 182-543-7300 Expedited prior authorization (EPA). (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes.

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

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

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

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

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

WAC 182-543-8000 DME—Billing general. (1) A provider must not bill the ((~~department~~)) medicaid agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

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

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

WAC 182-543-8100 DME—Billing for managed care clients. If a fee-for-service (FFS) client enrolls in a ((~~department-contracted~~)) medicaid agency-contracted managed care organization (MCO), the following apply:

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

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

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

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

(b) The ((~~department~~)) agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070; then

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

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

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

(b) The ((~~department~~)) agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070; then

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

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

WAC 182-543-8200 ((~~DME—~~))Billing for clients eligible for medicare and medicaid. If a client is eligible for both medicare and medicaid, the following apply:

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

(2) In accordance with WAC ((~~388-502-0110~~)) 182-502-0110(3):

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

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

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

WAC 182-543-9000 DME and related supplies, complex rehabilitation, prosthetics, orthotics, medical supplies and related services—General reimbursement. (1) The ((~~department~~)) medicaid agency pays qualified providers who meet all of the conditions in WAC ((~~388-502-0100~~)) 182-502-0100, for durable medical equipment (DME), supplies, repairs, and related services provided on a fee-for-service (FFS) basis as follows:

(a) To ((~~department-enrolled~~)) agency-enrolled DME providers, qualified complex rehabilitation technology (CRT) suppliers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the

procedures and codes in the ((~~department's~~)) agency's current DME billing instructions; and

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

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

(a) Commercial ((~~databases~~)) data bases;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

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

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

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

(a) Providers' usual and customary charges; or

(b) Established rates, except as provided in WAC ((~~388-543-8200~~)) 182-543-8200.

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

(7) The ((~~department~~)) agency does not pay for medical equipment and/or services provided to a client who is enrolled in a ((~~department-contracted~~)) agency-contracted managed care plan, but who did not use one of the plan's participating providers.

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

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

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

(c) Telephone calls;

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

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

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

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

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

((~~(i)~~)) (a) Hospice providers' per diem reimbursement;

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

((~~(iii)~~)) (c) Managed care plans' capitation rate;

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

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

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

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

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

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

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

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

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

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

(13) See WAC ((~~388-543-9100, 388-543-9200, 388-543-9300, and 388-543-9400~~)) 182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400 for other reimbursement methodologies.

AMENDATORY SECTION (Amending WSR 12-16-059, filed 7/30/12, effective 8/30/12)

WAC 182-543-9200 Reimbursement method—Wheelchairs. (1) The agency reimburses a DME provider for purchased wheelchairs based on the ((~~specific brand and model of wheelchair dispensed. The agency decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:~~

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

~~(b) Product quality;~~

~~(c) Cost; and~~

~~(d) Available alternatives~~)) assigned health care common procedure coding system (HCPCS) code. The agency requires providers to make sure the specific brand and model of wheelchairs dispensed are coded according to the Centers for Medicare and Medicaid Services' (CMS) pricing, data analysis, and coding (PDAC) web site.

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

(a) The current medicare fees;

(b) ((~~The actual invoice for the specific item~~)) A pricing cluster; or

(c) On a by-report basis.

(3) Establishing reimbursement rates for purchased wheelchairs based on pricing clusters.

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

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

(i) A client's medical needs;

(ii) Product quality;

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

(iv) Cost.

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

(4) The agency evaluates a by-report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate for these items at a percentage of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of January 31st of the base year, or a percentage of the wholesale acquisition cost (AC). The agency uses the following percentages:

(((~~(i)~~))) (a) For basic standard wheelchairs, sixty-five percent of MSRP or one hundred forty percent of AC;

(((~~(ii)~~))) (b) For ((~~add-on accessories and~~)) parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(((~~(iii)~~))) (c) For ((~~up-charge modifications and~~)) seat and back cushions, eighty percent of MSRP or one hundred forty percent of AC((~~;~~

~~(iv) For all other manual wheelchairs, eighty percent of MSRP or one hundred forty percent of AC; and~~

~~(v) For all other power-drive wheelchairs, eighty-five percent of MSRP or one hundred forty percent of AC.~~

~~(3)~~)).

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

NEW SECTION

WAC 182-543-9250 Reimbursement method—Complex rehabilitation technology. (1) The agency reimburses a complex rehabilitation technology (CRT) provider for purchased CRT products based on the assigned health care common procedure coding system (HCPCS) code. The agency requires providers to make sure the specific brand and model of CRT products dispensed are coded according to the Centers for Medicare and Medicaid Services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates, and updates the maximum allowable fees at least once yearly for CRT products using the lesser of the following:

(a) The current medicare fees;

(b) A pricing cluster; or

(c) On a by-report basis.

(3) Establishing reimbursement rates for purchased CRT products based on pricing clusters.

(a) A pricing cluster is based on a specific HCPCS code.

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

(i) A client's medical needs;

(ii) Product quality;

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

(iv) Costs.

(c) When establishing the fee for CRT products in a pricing cluster, the maximum allowable fee is the median amount of available manufacturer's list prices for all brands/models as noted in (b) of this subsection.

(4) The agency evaluates by-report (BR) items, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency calculates the reimbursement rate for these items at a percentage of the manufacturer's suggested retail price (MSRP) as of January 31st of the base year, or a percentage of the wholesale acquisition cost (AC) from the manufacturer's invoice. The agency uses the following percentages:

(a) For add-on CRT accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(b) For up-charge modifications, seating systems, back and seat cushions, eighty percent of MSRP or one hundred forty percent of AC;

(c) For CRT manual wheelchair base, eighty percent of MSRP or one hundred forty percent of AC; and

(d) For CRT power-drive wheelchair base, eighty-five percent of MSRP or one hundred forty percent of AC.

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

WSR 14-02-082
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 12:48 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: This rule creates a habilitative services section (WAC 182-545-400) as required under the Patient Protection and Affordable Care Act. WAC 182-545-900 and 182-551-2110 must be updated to reflect the creation of habilitative services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-545-900 and 182-551-2110.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148).

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: This rule is necessary to create a habilitative services section by January 1, 2014, to timely comply with service requirements in the Patient Protection and Affordable Care Act, and to update related sections to reflect the creation of habilitative services.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 2, 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 1, Amended 2, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

NEW SECTION

WAC 182-545-400 Habilitative services. (1) Habilitative services are medically necessary services to assist the client in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment.

(2) Eligibility is limited to clients who are enrolled in the alternative benefits plan defined in WAC 182-501-0060 and who have a diagnosis which is one of the qualifying conditions listed in the medicaid provider guide for habilitative services. Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for habilitative services through their MCO.

(3) The following licensed health professionals may enroll with the agency to provide habilitative services within their scope of practice to eligible clients:

(a) Physiatrists;

(b) Occupational therapists;

(c) Occupational therapy assistants supervised by a licensed occupational therapist;

(d) Physical therapists;

(e) Physical therapist assistants supervised by a licensed physical therapist;

(f) Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; and

(g) Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate.

(4) The agency pays for habilitative services that are:

(a) Covered within the scope of the client's alternative benefit plan under WAC 182-501-0060;

(b) Medically necessary;

(c) Within currently accepted standards of evidence-based medical practice;

(d) Ordered by a physician, physician assistant, or an advanced registered nurse practitioner;

(e) Begun within thirty calendar days of the date ordered;

(f) Provided by one of the health professionals listed in subsection (3) of this section;

(g) Authorized under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid provider guides and published provider notices;

(h) Billed under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid provider guides and published provider notices; and

(i) Provided as part of a habilitative treatment program:

(i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC; or

(iii) In a neurodevelopmental center, as described in WAC 182-545-900.

(5) For billing purposes under this section:

(a) Each fifteen minutes of timed procedure code equals one unit.

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(c) Duplicate services for habilitative services are not allowed for the same client when both providers are performing the same or similar procedure on the same day.

(d) The agency does not reimburse a health care professional for habilitative services performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.

(6) For eligible clients twenty years of age and younger, the agency covers unlimited outpatient habilitative services.

(7) For eligible clients twenty-one years of age and older, the agency covers limited outpatient habilitative services that include an ongoing management plan for the client or the client's caregiver to support continued client progress. The agency limits outpatient habilitative services as follows:

(a) Occupational therapy, per client, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge; and

(C) Twenty-four units of occupational therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when the client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency.

(b) Physical therapy, per client, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when the client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency.

(c) Speech therapy, per client, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when:

(A) The client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency; or

(B) The client has a speech deficit caused by the qualifying condition which requires a speech generating device.

(d) Two durable medical equipment needs assessments, per client, per year. The agency covers devices and other durable medical equipment for habilitative purposes to treat qualified conditions under chapter 182-543 WAC.

(e) Two program units of orthotics management and training of upper and lower extremities, per client, per day.

(f) Two program units for checkout for prosthetic or orthotic use, per established client, per year.

(g) One muscle testing procedure, per client, per day.

(h) One wheelchair-needs assessment, per client, per year.

(8) The agency evaluates requests for outpatient habilitative services that exceed the limitations in this section under WAC 182-501-0169. Prior authorization is required for additional units when:

(a) The criteria for expedited prior authorization do not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) The provider requests it as a medically necessary service.

(9) The following services are not covered:

(a) Day habilitation services designed to provide training, structured activities, and specialized services to adults;

(b) Chore services to assist basic needs;

(c) Vocational services;

(d) Custodial services;

(e) Respite;

(f) Recreational care;

(g) Residential treatment;

(h) Social services; and

(i) Educational services of any kind.

AMENDATORY SECTION (Amending WSR 11-21-066, filed 10/17/11, effective 11/17/11)

WAC 182-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed by the agency;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, the agency requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to the agency; and

(c) Have an approved core provider agreement with the agency.

(3) Clients, twenty years of age or younger, may receive outpatient rehabilitation and habilitative services (occupational therapy, physical therapy, and speech therapy) in agency-approved neurodevelopmental centers.

(4) The agency reimburses neurodevelopmental centers for providing the following services to clients:

(a) Outpatient rehabilitation and habilitative services as described in chapter 182-545 WAC ((~~182-545-200~~)); and

(b) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in the agency's billing instructions.

(5) In order to be reimbursed, neurodevelopmental centers must meet the agency's billing requirements in WAC 182-502-0020, 182-502-0100 and 182-502-0150.

AMENDATORY SECTION (Amending WSR 11-21-066, filed 10/17/11, effective 11/17/11)

WAC 182-551-2110 Home health services—Covered specialized therapy. The agency covers specialized therapy (((~~(also known as outpatient rehabilitation)~~)), including outpatient rehabilitation and habilitative services, in an in-home setting by a home health agency. ((~~See chapter 182-545 WAC outpatient rehabilitation for coverage and limitations.~~)) Outpatient rehabilitation and habilitative services are described in chapter 182-545 WAC. Specialized therapy is defined in WAC 182-551-2010.

WSR 14-02-083
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 1:58 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The health care authority is updating the client eligibility sections of the health care services chapters to align with the changes resulting from the implementation of Washington apple health and medicaid expansion.

Citation of Existing Rules Affected by this Order: Amending WAC 182-537-0300, 182-540-110, 182-544-0100, 182-545-200, 182-546-0150, 182-546-5300, 182-551-1200, 182-551-2020, 182-552-0100, 182-553-300, and 182-554-300.

Statutory Authority for Adoption: RCW 41.05.021; Patient Protection and Affordable Care Act (Public Law 111-148).

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: Without the emergency adoption of this rule, the program services rules would not reflect the January 1, 2014, changes resulting from the implementation of the Affordable Care Act, and thereby would not be compliant with federal law. A CR-101 has been filed under WSR 13-22-096 to initiate the permanent rule-making process.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 11, 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 11, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

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

WAC 182-537-0300 School-based health care services for children in special education—Client eligibility. Children in special education must be receiving Title XIX Medicaid under a Washington apple health (WAH) categorically needy program (CNP) or WAH medically needy program (MNP) to be eligible for school-based health care services. Eligible children enrolled in a managed care organization (MCO) receive school-based health care services on a fee-for-service basis.

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

WAC 182-540-110 Eligibility. (1) To be eligible for the kidney center services described in this section, a ((~~client~~)) person must be diagnosed with end-stage renal disease (ESRD) or acute renal failure and be covered under ((~~one of the following programs~~)):

(a) ((~~Categorically needy program (CNP);~~

~~(b) Children's health insurance program (CHIP);~~

~~(c) General assistance unemployable (GAU);~~

~~(d) Limited casualty program - Medically needy program (MNP);~~

~~(e)~~)) One of the Washington apple health programs listed in the table in WAC 182-501-0060;

(b) Alien emergency medical; or

(((~~f~~))) (c) Qualified medicare beneficiary (QMB)—(MAA pays only for medicare premium, coinsurance and deductible).

(2) Managed care enrollees must have dialysis services arranged directly through their designated plan.

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

WAC 182-544-0100 Vision care—Eligible ((~~clients~~)) persons—Twenty years of age and younger. This section applies to eligible ((~~clients~~)) persons who are twenty years of age and younger.

(1) Vision care is available to ((~~clients~~)) persons who are eligible for services under one of the ((~~following medical assistance~~)) Washington apple health programs((~~:~~

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

~~(b) Categorically needy program - State children's health insurance program (CNP-SCHIP);~~

~~(c) Children's health care programs as defined in WAC 388-505-0210;~~

~~(d) Limited casualty program - Medically needy program (LCP-MNP);~~

~~(e) Disability lifeline (formerly general assistance (GA-U/ADATSA)) (within Washington state or designated border cities); and~~

~~(f)~~)) listed in the table in WAC 182-501-0060 or be eligible for the alien emergency medical (AEM) program as described in WAC ((~~388-438-0115, when the medical services are necessary to treat a qualifying emergency medical condition only~~)) 182-507-0110.

(2) Eligible ((~~clients~~)) persons who are enrolled in ((~~a department contracted~~)) an agency-contracted managed care organization (MCO) are eligible under fee-for-service for covered vision care that are not covered by their plan and subject to the provisions of this chapter and other applicable WAC.

AMENDATORY SECTION (Amending WSR 11-21-066, filed 10/17/11, effective 11/17/11)

WAC 182-545-200 Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy). (1) The following health professionals may enroll with the agency, as defined in WAC 182-500-0010, to provide outpa-

tient rehabilitation (which includes occupational therapy, physical therapy, and speech therapy) within their scope of practice to eligible ((~~clients~~)) persons:

(a) A physiatrist;

(b) A licensed occupational therapist;

(c) A licensed occupational therapy assistant (OTA) supervised by a licensed occupational therapist;

(d) A licensed physical therapist;

(e) A physical therapist assistant supervised by a licensed physical therapist;

(f) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; and

(g) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate.

(2) ((~~Clients in the following agency~~)) Persons covered by one of the Washington apple health programs listed in the table in WAC 182-501-0060 or receiving home health care services as described in chapter 182-551 WAC (subchapter II) are eligible to receive outpatient rehabilitation as described in this chapter((~~:~~

~~(a) Categorically needy program (CNP);~~

~~(b) Categorically needy program-state children's health insurance program (CNP-SCHIP);~~

~~(c) Children's health care programs as defined in WAC 388-505-0210;~~

~~(d) Medical care services as described in WAC 182-508-0005 (within Washington state or border areas only);~~

~~(e) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (within Washington state or border areas only);~~

~~(f) Medically needy program (MNP) only when the client is either:~~

~~(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 182-534 WAC; or~~

~~(ii) Receiving home health care services as described in chapter 182-551 WAC, subchapter II~~)).

(3) ((~~Clients~~)) Persons who are enrolled in an agency-contracted managed care organization (MCO) must arrange for outpatient rehabilitation directly through his or her agency-contracted MCO.

(4) The agency pays for outpatient rehabilitation when the services are:

(a) Covered;

(b) Medically necessary;

(c) Within the scope of the eligible ((~~client's~~)) person's medical care program;

(d) Ordered by a physician, physician's assistant (PA) or an advanced registered nurse practitioner (ARNP);

(e) Within currently accepted standards of evidence-based medical practice;

(f) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and numbered memoranda;

(g) Begun within thirty calendar days of the date ordered;

(h) Provided by one of the health professionals listed in subsection (1) of this section;

(i) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and numbered memoranda; and

(j) Provided as part of an outpatient treatment program:

(i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC;

(iii) In a neurodevelopmental center, as described in WAC 182-545-900; or

(iv) For children with disabilities, age two or younger, in natural environments including the home and community setting in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(5) For eligible ((~~clients~~)) persons, twenty years of age and younger, the agency covers unlimited outpatient rehabilitation.

(6) For ((~~clients~~)) persons twenty-one years of age and older, the agency covers a limited outpatient rehabilitation benefit.

(7) Outpatient rehabilitation services for ((~~clients~~)) persons twenty-one years of age and older must:

(a) Restore, improve, or maintain the ((~~client's~~)) person's level of function that has been lost due to medically documented injury or illness; and

(b) Include an on-going management plan for the ((~~client~~)) person and/or the ((~~client's~~)) person's caregiver to support timely discharge and continued progress.

(8) For eligible adults, twenty-one years of age and older, the agency limits coverage of outpatient rehabilitation as follows:

(a) Occupational therapy, per ((~~client~~)) person, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge; and

(C) Twenty-four units of occupational therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The ((~~client's~~)) person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(III) Burns - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries

involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Swallowing deficits due to injury or surgery to face, head, or neck;

(XI) Spinal cord injury which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XII) As part of a botulinum toxin injection protocol when botulinum toxin has been prior authorized by the agency.

(b) Physical therapy, per ((~~client~~)) person, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of physical therapy may be available to continue treatment initiated under the original twenty-four units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The ((~~client's~~)) person's diagnosis is any of the following:

(I) Acute, open, or chronic nonhealing wounds;

(II) Brain injury, which occurred within the past twenty-four months, with residual functional deficits;

(III) Burns - Second and/or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Lymphedema;

(VI) Major joint surgery - Partial or total replacement only;

(VII) Muscular-skeletal disorders such as complex fractures which required surgical intervention or surgeries involving spine or extremities (e.g., arm, hand, shoulder, leg, foot, knee, or hip);

(VIII) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infective polyneuritis (Guillain-Barre));

(IX) Reflex sympathetic dystrophy;

(X) Spinal cord injury, which occurred within the past twenty-four months, resulting in paraplegia or quadriplegia; or

(XI) As part of a botulinum toxin injection protocol when botulinum toxin has been prior approved by the agency.

(c) Speech therapy, per ((~~client~~)) person, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to six additional units of speech therapy may be available to continue treatment initiated under the original six units when the criteria below is met:

(A) To continue treatment of the original qualifying condition; and

(B) The ((~~client's~~)) person's diagnosis is any of the following:

(I) Brain injury, which occurred within the past twenty-four months, with residual cognitive and/or functional deficits;

(II) Burns of internal organs such as nasal oral mucosa or upper airway;

(III) Burns of the face, head, and neck - Second or third degree only;

(IV) Cerebral vascular accident, which occurred within the past twenty-four months, with residual functional deficits;

(V) Muscular-skeletal disorders such as complex fractures which require surgical intervention or surgery involving the vault, base of the skull, face, cervical column, larynx, or trachea;

(VI) Neuromuscular disorders which are affecting function (e.g., amyotrophic lateral sclerosis (ALS), active infection polyneuritis (Guillain-Barre));

(VII) Speech deficit due to injury or surgery to face, head, or neck;

(VIII) Speech deficit which requires a speech generating device;

(IX) Swallowing deficit due to injury or surgery to face, head, or neck; or

(X) As part of a botulinum toxin injection protocol when botulinum toxin has been prior approved by the agency.

(d) Durable medical equipment (DME) needs assessments, two per ((~~client~~)) person, per year.

(e) Orthotics management and training of upper and/or lower extremities, two program units, per ((~~client~~)) person, per day.

(f) Orthotic/prosthetic use, two program units, per ((~~client~~)) person, per year.

(g) Muscle testing, one procedure, per ((~~client~~)) person, per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical and occupational therapy procedures.

(h) Wheelchair needs assessment, one per ((~~client~~)) person, per year.

(9) For the purposes of this chapter:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(10) For expedited prior authorization (EPA):

(a) A provider must establish that:

(i) The ((~~client's~~)) person's condition meets the clinically appropriate EPA criteria outlined in this section; and

(ii) The services are expected to result in a reasonable improvement in the ((~~client's~~)) person's condition and achieve the ((~~client's~~)) person's therapeutic individual goal within sixty calendar days of initial treatment;

(b) The appropriate EPA number must be used when the provider bills the agency;

(c) Upon request, a provider must provide documentation to the agency showing how the ((~~client's~~)) person's condition met the criteria for EPA; and

(d) A provider may request expedited prior authorization once per year, per ((~~client~~)) person, per each therapy type.

(11) The agency evaluates a request for outpatient rehabilitation that is in excess of the limitations or restrictions, according to WAC 182-501-0169. Prior authorization may be requested for additional units when:

(a) The criteria for an expedited prior authorization does not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits;

(c) A new qualifying condition arises after the initial six visits are used.

(12) Duplicate services for outpatient rehabilitation are not allowed for the same ((~~client~~)) person when both providers are performing the same or similar procedure(s).

(13) The agency does not pay separately for outpatient rehabilitation that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(14) The agency does not reimburse a health care professional for outpatient rehabilitation performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.

AMENDATORY SECTION (Amending WSR 13-16-006, filed 7/25/13, effective 8/25/13)

WAC 182-546-0150 Client eligibility for ambulance transportation. (1) Except for clients in the Family Planning Only and TAKE CHARGE programs, fee-for-service clients are eligible for ambulance transportation to covered services with the following limitations:

(a) Clients in the following Washington apple health (WAH) programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 182-501-0175:

(i) Medical care services (MCS) as described in WAC 182-508-0005;

(ii) ((~~Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) as described in WAC 182-508-0320;~~

~~(iii)~~)) Alien emergency medical (AEM) services as described in chapter 182-507 WAC.

(b) Clients in the WAH categorically needy/qualified medicare beneficiary (CN/QMB) and WAH medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 182-546-0400(5).

(2) Clients enrolled in an agency-contracted managed care organization (MCO) must coordinate:

(a) Ground ambulance services through their designated MCO, subject to the MCO coverage and limitations; and

(b) Air ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter.

(3) Clients enrolled in the agency's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with the agency's requirements. The agency pays for covered services for these clients according to the agency's published medicaid provider guides and provider notices.

(4) Clients under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to individuals who are being detained involuntarily for mental health treatment and being transported to or from bordering cities. See also WAC 182-546-4000.

(5) See WAC 182-546-0800 and 182-546-2500 for additional limitations on out-of-state coverage and coverage for clients with other insurance.

(6) The agency does not pay for ambulance services for jail inmates and persons living in a correctional facility. See WAC 182-503-0505(5).

AMENDATORY SECTION (Amending WSR 11-17-032, filed 8/9/11, effective 8/9/11)

WAC 182-546-5300 Nonemergency transportation—Client eligibility. (1) The ((~~department~~)) agency pays for nonemergency transportation for ((~~medical assistance~~)) Washington apple health (WAH) clients as described in WAC 182-501-0060, including ((~~clients~~)) persons enrolled in ((~~a department-contracted~~)) an agency-contracted managed care organization (MCO), to and from health care services when the health care service(s) meets the requirements in WAC ((~~388-546-5500~~)) 182-546-5500.

(2) ((~~Clients~~)) Persons assigned to the patient review and coordination (PRC) program according to WAC ((~~388-501-0135~~)) 182-501-0135 may be restricted to certain providers.

(a) Brokers may authorize transportation of a PRC client to only those providers to whom the ((~~client~~)) person is assigned or referred by their primary care provider (PCP), or for covered services which do not require referrals.

(b) If a ((~~client~~)) person assigned to PRC chooses to receive service from a provider, pharmacy, and/or hospital that is not in the ((~~client's~~)) person's local community, the ((~~client's~~)) person's transportation is limited per WAC 388-546-5700.

AMENDATORY SECTION (Amending WSR 13-04-094, filed 2/6/13, effective 3/9/13)

WAC 182-551-1200 Client eligibility for hospice care. (1) A ((~~client~~)) person who elects to receive hospice care must be eligible for one of the ((~~following medical assistance~~)) Washington apple health programs listed in the table in WAC 182-501-0060 or be eligible for the alien emergency medical (AEM) program (see WAC 182-507-0110), subject to the restrictions and limitations in this chapter and other WAC((~~:~~

~~(a) Categorically needy (CN);~~

~~(b) Children's health care as described in WAC 182-505-0210;~~

~~(c) Medically needy (MN); or~~

~~(d) Alien emergency medical (AEM) as described in WAC 182-507-0110, when the medical services are necessary to treat a qualifying emergency medical condition~~)).

(2) A hospice agency is responsible to verify a ((~~client's~~)) person's eligibility with the ((~~client~~)) person or the ((~~client's~~)) person's department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO).

(3) A ((~~client~~)) person enrolled in one of the medicaid agency's managed care organizations (MCO) must receive all hospice services, including facility room and board, directly through that MCO. The MCO is responsible for arranging and providing all hospice services for an MCO client.

(4) A ((~~client~~)) person who is also eligible for medicare hospice under part A is not eligible for hospice care through the medicaid agency's hospice program. The medicaid agency does pay hospice nursing facility room and board for these ((~~clients~~)) persons if the ((~~client~~)) person is admitted to a nursing facility or hospice care center (HCC) and is not receiving general inpatient care or inpatient respite care. See also WAC 182-551-1530.

(5) A ((~~client~~)) person who meets the requirements in this section is eligible to receive hospice care through the medicaid agency's hospice program when all of the following is met:

(a) The ((~~client's~~)) person's physician certifies the ((~~client~~)) person has a life expectancy of six months or less.

(b) The ((~~client~~)) person elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 182-551-1310.

(c) The hospice agency serving the ((~~client~~)) person:

(i) Notifies the medicaid agency's hospice program within five working days of the admission of all ((~~clients~~)) persons, including:

(A) Medicaid-only ((~~clients~~)) persons;

(B) Medicaid-medicare dual eligible ((~~clients~~)) persons;

(C) Medicaid ((~~clients~~)) persons with third-party insurance; and

(D) Medicaid-medicare dual eligible ((~~clients~~)) persons with third-party insurance.

(ii) Meets the hospice agency requirements in WAC 182-551-1300 and 182-551-1305.

(d) The hospice agency provides additional information for a diagnosis when the medicaid agency requests and determines, on a case-by-case basis, the information that is needed for further review.

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

WAC 182-551-2020 Home health services—Eligible ((~~clients~~)) persons. (1) ((~~Clients~~)) Persons in the ((~~following~~)) Washington apple health (WAH) fee-for-service programs listed in the table in WAC 182-501-0060 are eligible to receive home health services subject to the limitations described in this chapter. ((~~Clients~~)) Persons enrolled in ((~~a department-contracted~~)) an agency-contracted managed care organization (MCO) receive all home health services through their designated plan.

(((~~(a) Categorically needy program (CNP);~~

~~(b) Limited casualty program - Medically needy program (LCP-MNP); and~~

~~(c) Medical care services (MCS) under the following programs:~~

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

~~(ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).~~))

(2) The ((~~department~~)) agency does not cover home health services under the home health program for ((~~clients~~)) persons in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. The ((~~department~~)) agency or its designee evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC ((~~388-501-0165~~)) 182-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

(a) The ((~~client~~)) person requires hospital care due to an ((~~emergent~~)) emergency medical condition as described in WAC ((~~388-500-0005~~)) 182-500-0030; and

(b) The ((~~department~~)) agency or its designee authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

AMENDATORY SECTION (Amending WSR 12-14-022, filed 6/25/12, effective 8/1/12)

WAC 182-552-0100 Respiratory care—Client eligibility. (1) ((~~Clients in~~)) To receive respiratory care, a person must be eligible for one of the ((~~following medical assistance~~)) Washington apple health programs ((~~are eligible for respiratory care:~~

~~(a) Categorically needy (CN);~~

~~(b) Children's health care as described in WAC 388-505-0210;~~

~~(c) Medically needy (MN);~~

~~(d) Medical care services as described in WAC 182-508-0005; and~~

~~(e)~~)) listed in the table in WAC 182-501-0060 or be eligible for the alien emergency medical (AEM) (as described in WAC ((~~388-438-0110, when the medical services are necessary to treat a qualifying emergency medical condition~~)) 182-507-0110).

(2) ((~~Clients~~)) Persons who are enrolled in an agency-contracted managed care organization (MCO) must arrange for all respiratory care directly through his or her MCO.

(3) For ((~~clients~~)) persons residing in skilled nursing facilities, boarding homes, and adult family homes, see WAC 182-552-0150.

(4) ((~~Clients~~)) Persons who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for respiratory care.

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

WAC 182-553-300 Home infusion therapy/parenteral nutrition program—Client eligibility and assign-

ment. (1) ((~~Clients in the following medical assistance programs are eligible~~)) To receive home infusion therapy and parenteral nutrition, subject to the limitations and restrictions in this section and other applicable WAC((~~:~~

~~(a) Categorically needy program (CNP);~~

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

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

~~(d) Limited casualty program - Medically needy program (LCP-MNP)~~)), a person must be eligible for one of the Washington apple health programs listed in the table in WAC 182-501-0060.

(2) ((~~Clients~~)) Persons enrolled in ((~~a department-contracted~~)) an agency-contracted managed care organization (MCO) are eligible for home infusion therapy and parenteral nutrition through that plan.

(3) ((~~Clients~~)) Persons eligible for home health program services may receive home infusion related services according to WAC ((~~388-551-2000 through 388-551-3000~~)) 182-551-2000 through 182-551-3000.

(4) To receive home infusion therapy, a ((~~client~~)) person must:

(a) Have a written physician order for all solutions and medications to be administered.

(b) Be able to manage their infusion in one of the following ways:

(i) Independently;

(ii) With a volunteer caregiver who can manage the infusion; or

(iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).

(c) Be clinically stable and have a condition that does not warrant hospitalization.

(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the ((~~client~~)) person is not able to comply, the ((~~client's~~)) person's caregiver may comply.

(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the ((~~client~~)) person is not able to consent, the ((~~client's~~)) person's legal representative may consent.

(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:

(i) Running water;

(ii) Electricity;

(iii) Telephone access; and

(iv) Receptacles for proper storage and disposal of drugs and drug products.

(5) To receive parenteral nutrition, a ((~~client~~)) person must meet the conditions in subsection (4) of this section and:

(a) Have one of the following that prevents oral or enteral intake to meet the ((~~client's~~)) person's nutritional needs:

(i) Hyperemesis gravidarum; or

(ii) An impairment involving the gastrointestinal tract that lasts three months or longer.

(b) Be unresponsive to medical interventions other than parenteral nutrition; and

(c) Be unable to maintain weight or strength.

(6) A ((~~client~~)) person who has a functioning gastrointestinal tract is not eligible for parenteral nutrition program services when the need for parenteral nutrition is only due to:

(a) A swallowing disorder;

(b) Gastrointestinal defect that is not permanent unless the ((~~client~~)) person meets the criteria in subsection (7) of this section;

(c) A psychological disorder (such as depression) that impairs food intake;

(d) A cognitive disorder (such as dementia) that impairs food intake;

(e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;

(f) A side effect of medication; or

(g) Renal failure or dialysis, or both.

(7) A ((~~client~~)) person with a gastrointestinal impairment that is expected to last less than three months is eligible for parenteral nutrition only if:

(a) The ((~~client's~~)) person's physician or appropriate ((~~medial [medical]~~)) medical provider has documented in the ((~~client's~~)) person's medical record the gastrointestinal impairment is expected to last less than three months;

(b) The ((~~client~~)) person meets all the criteria in subsection (4) of this section;

(c) The ((~~client~~)) person has a written physician order that documents the ((~~client~~)) person is unable to receive oral or tube feedings; and

(d) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

(8) A ((~~client~~)) person is eligible to receive intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and

(b) The ((~~client~~)) person meets the criteria in subsection (4) and (5) of this section and other applicable WAC.

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

WAC 182-554-300 Enteral nutrition—Client eligibility. (1) To receive oral or tube-delivered enteral nutrition products, equipment, and related supplies, ((~~clients~~)) a person must be eligible for one of the ((~~following medical assistance~~)) Washington apple health programs((~~:~~

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

~~(b) Categorically needy program - State children's health insurance program (CNP-SCHIP);~~

~~(c) Children's health care programs as defined in WAC 388-505-0210;~~

~~(d) Limited casualty program - Medically needy program (LCP-MNP);~~

~~(e) General assistance (GAU/ADATSA); and~~

~~(f) Emergency medical only programs when the services are necessary to treat the client's emergency medical condition.~~

~~(2) Clients who are enrolled in a department-contracted managed care organization (MCO) must arrange for enteral nutrition products, equipment, and related supplies directly through his or her department-contracted MCO.~~

~~(3)~~)) listed in the table in WAC 182-501-0060 or be eligible for the alien emergency medical (AEM) program (see WAC 182-507-0110).

(2) For clients who reside in a nursing facility, adult family home, assisted living facility, boarding home, or any other residence where the provision of food is included in the daily rate, oral enteral nutrition products are the responsibility of the facility to provide in accordance with chapters 388-76, 388-97 and 388-78A WAC.

(((~~(4)~~))) (3) For clients who reside in a state-owned facility (i.e. state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital) enteral nutrition products, equipment, and related supplies are the responsibility of the state-owned facility to provide.

(((~~(5)~~))) (4) Clients who have elected and are eligible to receive the department's hospice benefit must arrange for enteral nutrition products, equipment and related supplies directly through the hospice benefit.

(((~~(6)~~))) (5) Children who qualify for supplemental nutrition from the women, infants, and children (WIC) program must receive supplemental nutrition directly from that program unless the client meets the limited circumstances in WAC 388-554-500 (1)(d).

WSR 14-02-085
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 2:34 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The health care authority is updating its program benefits packages and scope of health care service categories effective January 1, 2014, to comply with changes required by the federal Affordable Care Act and recently passed state budget. Some of the changes include adding alternative benefit plan (ABP) as a program; adding applied behavior analysis (ABA) and habilitation services as categories of service; adding preventive exams, vaccinations, and screening, brief intervention, referral and treatment (SBIRT) for chemical dependency to health care professional services; defining habilitation services; and adding naturopathy to the definition of "physician."

Citation of Existing Rules Affected by this Order: Amending WAC 182-500-0085, 182-501-0060, and 182-501-0065.

Statutory Authority for Adoption: RCW 41.05.021; 3ESHB 5034 (chapter 4, Laws of 2013); and the Patient Protection and Affordable Care Act (Public Law 111-148).

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: Without the emergency adoption of this rule, the program benefits packages and scope of health care services chart would not reflect the January 1, 2014, changes resulting from the implementation of the Affordable Care Act and the recently passed legislative budget bill. A CR-101 was filed under WSR 13-17-105 to initiate the permanent rule-making process. Currently, a draft of the rule has been distributed to stakeholders for their review and comment.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 2, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

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

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 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 3, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

WAC 182-500-0085 Medical assistance definitions—P. "Patient transportation" means client transportation to and/or from covered health care services under federal and state health care programs.

"Physician" means a doctor of medicine, osteopathy, naturopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Prescribing provider" means any physician or other health care professional authorized by law or rule to prescribe drugs for current clients of Washington's health care programs administered by the agency.

"Prior authorization" is the requirement that a provider must request, on behalf of a client and when required by rule, the agency's or the agency's designee's approval to render a health care service or write a prescription in advance of the client receiving the health care service or prescribed drug, device, or drug-related supply. The agency's or the agency's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body.

"Provider" means an institution, agency, or person that is licensed, certified, accredited, or registered according to Washington state laws and rules, and:

(1) Has signed a core provider agreement or signed a contract with the agency or the agency's designee, and is authorized to provide health care, goods, and/or services to medical assistance clients; or

(2) Has authorization from a managed care organization (MCO) that contracts with the agency or the agency's designee to provide health care, goods, and/or services to eligible medical assistance clients enrolled in the MCO plan.

"Public institution" see "institution" in WAC 182-500-0050.

AMENDATORY SECTION (Amending WSR 13-15-044, filed 7/11/13, effective 8/11/13)

WAC 182-501-0060 Health care coverage—Program benefits packages—Scope of service categories. (1) This rule provides a table that ((~~lists~~)):

(a) Lists the following Washington apple health (WAH) programs:

(i) The alternative benefits plan (ABP) medicaid;

(ii) Categorically needy (CM) medicaid((~~,~~));

(iii) Medically needy (MN) medicaid((~~,~~));and

(iv) Medical care services (MCS) programs (includes incapacity-based and aged, blind, and disabled medical care services ((~~and the medical component of the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program~~))); and

(b) The benefit((~~s~~)) packages showing what service categories are included for each program.

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

(3) Services covered within each service category included in a benefit((~~s~~)) 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.

(d) Are paid for by the agency or its designee and subject to review both before and after payment is made. The agency 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 does not pay for covered services, equipment, or supplies that:

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

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

(c) Are included in an agency or its designee waiver program identified in chapter 182-515 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 not addressed in the table:

(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) The following programs are not addressed in the table:~~

~~(i)~~)) Alien emergency medical (AEM) services (see chapter 182-507 WAC); and

((~~(ii)~~)) (b) TAKE CHARGE program (see WAC 182-532-700 through 182-532-790).

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

(a) Under the ABP, 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) 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 rules and agency issuances.

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

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

Service Categories	ABP 20-	ABP 21+	CN[1] 20-	CN 21+	MN 20-	MN 21+	MCS
Ambulance (ground and air)	Y		Y	Y	Y	Y	Y
Applied behavior analysis (ABA)	Y	N	Y	N	Y	N	N
Behavioral health services							
• Mental health (MH) inpatient care	Y	Y	Y	Y	Y	Y	Y
• MH outpatient community care	Y	Y	Y	Y	Y	Y	Y[2]
• MH psychiatric visits	Y	Y	Y	Y	Y	Y	Y[3]
• MH medication management	Y	Y	Y	Y	Y	Y	Y
• Substance use disorder (SUD) detoxification	Y	Y	Y	Y	Y	Y	Y
• SUD diagnostic assessment	Y	Y	Y	Y	Y	Y	Y
• SUD residential treatment	Y	Y	Y	Y	Y	Y	Y
• SUD outpatient treatment	Y	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y	Y

Service Categories	ABP 20-	ABP 21+	CN[1] 20-	CN 21+	MN 20-	MN 21+	MCS
Dental services	Y	Y	Y	Y[4]	Y	Y[4]	Y[4]
Diagnostic services (lab and X ray)	Y	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N	N
Habilitative services	Y	Y	N	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y	Y
Hearing evaluations	Y	Y	Y	Y	Y	Y	Y
Hearing aids	Y	N	Y	N	Y	N	N
Home health services	Y	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y	N
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y
Maternity care and delivery services	Y	Y	Y	Y	Y	Y	Y
Medical equipment, durable (DME)	Y	Y	Y	Y	Y	Y	Y
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y	Y	Y
Medical nutrition services	Y	Y	Y	Y	Y	Y	Y
Nursing facility services	Y	Y	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y	Y	Y
Orthodontic services	Y	N	Y	N	Y	N	N
Out-of-state services	Y	Y	Y	Y	Y	Y	N
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	N	Y
Personal care services	Y	Y	Y	Y	N	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y	N
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y	Y
((~~Psychological evaluation~~[5]			~~Y~~	~~Y~~	~~Y~~	~~Y~~	~~N~~))
Reproductive health services	Y	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N	N
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N	N

[1] Clients enrolled in the ((~~children's health insurance program and the~~)) Washington apple health for kids and Washington apple health for kids with premium programs, which includes the children's health insurance program (CHIP), receive CN-scope of ((~~medical~~)) health care services.

[2] Restricted to incapacity-based MCS clients enrolled in managed care.

[3] Incapacity-based MCS clients can receive one psychiatric diagnostic evaluation per year and eleven monthly visits per year for medication management.

((~~[4] Restricted to those clients who meet the categorical requirements described in WAC 182-535-1060.~~

~~[5] Only two allowed per lifetime.~~))

AMENDATORY SECTION (Amending WSR 13-15-044, filed 7/11/13, effective 8/11/13)

WAC 182-501-0065 Health care coverage—Description of service categories ((~~of service~~)). This rule provides a brief description of the medical, dental, mental health, and substance use disorder (SUD) service categories listed in the table in WAC 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.

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

(a) **Ambulance -** Emergency medical transportation and ambulance transportation for nonemergency medical needs. (WAC 182-546-0001 through 182-546-4000.)

(b) **Applied behavior analysis (ABA) –** (WAC 182-531-1410 through 182-531-1434).

(c) **Behavioral health services -**

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

(ii) Mental health outpatient (community mental health) services - Nonemergency, psychological evaluation, 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) Mental health medication management. (WAC 182-531-1400.)

(v) Substance use disorder (SUD) detoxification. (WAC 182-508-0305 and 182-550-1100; WAC 182-556-0400(3).)

(vi) ((~~Substance use disorder~~)) SUD diagnostic assessment. (WAC 182-508-0330.)

(vii) ((~~Substance use disorder~~)) SUD residential treatment. (WAC 182-508-0310 through 182-508-0375; and WAC 182-556-0100.)

(viii) ((~~Substance use disorder~~)) SUD outpatient treatment. (WAC 182-508-0310 through 182-508-0375; WAC 182-533-0701 through 182-533-0730; WAC 182-556-0100 and 182-556-0400.)

(((~~c~~))) (d) **Blood, blood products, and related services -** Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. (WAC 182-550-1400 and 182-550-1500.)

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

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

(((~~f~~))) (g) **Early and periodic screening, diagnosis, and treatment (EPSDT) –** (Chapter 182-534 WAC and WAC 182-501-0050(10).)

(h) **Habilitative services –** (Chapter 182-545 WAC).

(i) **Health care professional services -** Office visits, ((~~emergency oral health,~~)) vaccinations, screening/brief intervention/referral to treatment (SBIRT), 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 182-531 WAC.)

(((~~g~~))) (j) **Hearing evaluations -** Audiology; diagnostic evaluations; hearing exams and testing. (WAC 182-531-0100 and 182-531-0375.)

(((~~h~~))) (k) **Hearing aids -** (Chapter 182-547 WAC.)

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

(((~~j~~))) (m) **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 182-551-1210 through 182-551-1850.)

(((~~k~~))) (n) **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 182-550 WAC.)

(((~~l~~))) (o) **Intermediate care facility/services for persons with intellectual disabilities -** Habilitative training, health-related care, supervision, and residential care. (Chapter 388-835 WAC.)

(((~~m~~))) (p) **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 182-533-0330.)

(((~~n~~))) (q) **Medical equipment, durable (DME) -** Wheelchairs, hospital beds, respiratory equipment; casts, splints, crutches, trusses, and braces. (Chapter 182-543 WAC.)

(((~~o~~))) (r) **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, and urological supplies. (Chapter 182-543 WAC.)

(((~~p~~))) (s) **Medical nutrition services -** Enteral and parenteral nutrition, including supplies. (Chapters 182-553 and 182-554 WAC.)

(((~~q~~))) (t) **Nursing facility services -** Nursing, therapies, dietary, and daily care services. (Chapter 388-97 WAC.)

(((~~r~~))) (u) **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 182-550-1900 and 182-556-0400.)

(((~~s~~))) (v) **Orthodontic services –** (Chapter 182-535A WAC).

(w) **Out-of-state services -** ((~~See~~)) (WAC 182-502-0120 ((~~for services out-of-state~~))).

(((~~t~~))) (x) **Outpatient rehabilitation services (OT, PT, ST) -** Evaluations, assessments, and treatment. (WAC 182-545-200.)

(((~~u~~))) (y) **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, 388-106-0200, 388-106-0300, 388-106-0600, 388-106-0700, 388-106-0745, and 388-106-0900.)

(((~~v~~))) (z) **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 182-530-2000.) Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(((~~(w)~~))) (aa) **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 182-551-3000.) For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(((~~(x)~~))) (bb) **Prosthetic/orthotic devices -** Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. (WAC 182-543-5000.)

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

~~(z)~~))) (cc) **Reproductive health services -** Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. (WAC 182-532-001 through 182-532-140.)

(((~~(aa)~~))) (dd) **Respiratory care (oxygen) -** All services, oxygen, equipment, and supplies related to respiratory care. (Chapter 182-552 WAC.)

(((~~(bb)~~))) (ee) **School-based medical services -** Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). (Chapter 182-537 WAC.)

(((~~(cc)~~))) (ff) **Vision care -** Eye exams, refractions, fittings, visual field testing, vision therapy, ocular prosthetics, and surgery. (WAC 182-531-1000.)

(((~~(dd)~~))) (gg) **Vision hardware -** Frames and lenses. (Chapter 182-544 WAC.)

WSR 14-02-086
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed December 30, 2013, 4:27 p.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: The health care authority needs to amend rules, create new rules in order to implement new federal regulations under the federal Patient Protection and Affordable Care Act. This filing is to correctly reference rules that are final January 1, 2014, in the long-term care medical rule in addition to the elimination of the presumptive disability program as an eligibility group.

Citation of Existing Rules Affected by this Order: Amending WAC 182-513-1301, 182-513-1305, 182-513-1315, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1364, 182-513-1365, 182-513-1366, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1400, 182-513-1405, 182-513-1415, 182-513-1425, 182-513-1430, 182-513-1450, 182-513-1455, 182-515-1500, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513, 182-515-1514, and 182-507-0125.

Statutory Authority for Adoption: RCW 41.05.021; chapter 74.39 RCW.

Other Authority: Patient Protection and Affordable Care Act established under Public Law 111-148; and Code of Federal Regulations at 42 C.F.R. § 431, 435, and 457, and at 45 C.F.R. § 155. Section 1917 of the Social Security Act.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that 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: Over the last year the agency has been working diligently with client advocates and other stakeholders in crafting the new rules to implement the provisions of the Affordable Care Act, including the expansion of medicaid. Although the permanent rule-making process is nearing completion, the permanent rules will not be effective by the October 1, 2013, deadline due in part to the anticipated receipt of final federal rules governing this process. Hence the need for the emergency adoption of these rules, while the permanent rule-making process is completed.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 33, 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 4, Amended 33, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 4, Amended 33, Repealed 0.

Date Adopted: December 30, 2013.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-507-0125 State-funded long-term care services program. (1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and ((~~disability services~~)) long-term supports administration (((~~ADSA~~))) (ALTSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

(a) In a person's own home, as described in WAC 388-106-0010;

(b) Nursing facility, as defined in WAC 388-97-0001;

(c) Adult family home, as defined in RCW 70.128.010;

(d) Assisted living facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(e) Enhanced adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(f) Adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Meet the general eligibility requirements for medical programs described in WAC ((~~388-503-0505~~)) 182-503-0505 (2) and (3)(((~~(a), (b), (c), and (f)~~))) with the exception of subsection (3)(c) and (d) of this section;

(b) Reside in one of the settings described in subsection (2) of this section;

(c) Attain institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC ((~~388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366~~)) 182-513-1363, 182-513-1364, or 182-513-1365;

(f) Not have equity interest in a primary residence more than the amount described in WAC ((~~388-513-1350 (7)(a)(ii)~~)) 182-513-1350; and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter ((~~388-561~~)) 182-516 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC ((~~388-475-0050~~)) 182-512-0050 (1), (2), and (3) must meet the financial requirements described in WAC ((~~388-513-1325, 388-513-1330, and 388-513-1350~~)) 182-513-1315.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC ((~~388-505-0250 or 388-505-0255~~)) 182-514-0230.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

(a) WAC ((~~388-513-1395~~)) 182-513-1395 for adults related to SSI; or

(b) WAC ((~~388-505-0255~~)) 182-514-0255 for adults up to age twenty-one related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC ((~~388-501-0060~~)) 182-500-0020.

(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual residing in a nursing home, see rules described in WAC ((~~388-513-1380~~)) 182-513-1380.

(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC ((~~388-515-1505~~)) 182-515-1505.

(c) For an individual eligible under the family institutional program, see WAC ((~~388-505-0265~~)) 182-514-0265.

(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.

(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters ((~~388-513~~)) 182-513 and ((~~388-515~~)) 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used.

Additional medical definitions that are not specific to LTC services can be found in WAC 182-500-0005 through 182-500-0110 Medical definitions.

Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property approximates the reasonable value of the property transferred.

"Aging and disability services (ADS)" means an umbrella agency for the behavioral health and service integration administration (BHSIA), aging and long-term support administration (ALTSA) and developmental disabilities administration (DDA) within the department of social and health services (DSHS).

"Aging and long-term supports administration (ALTSA)" means an administration within aging and disability services (ADS) of the department of social and health services (DSHS) and includes:

• Home and community services (HCS) that helps low income seniors and adults with disabilities and their families get information, support and services when long-term care is needed; and

• Residential care services (RCS) that regulates nursing facilities (NF), adult family homes (AFH), assisted living facilities (AL), intermediate care facilities for individuals with intellectual disabilities (ICF-ID), and certified community residential service providers and promotes and protects the health, safety, and well-being of individuals living in licensed or certified residential settings.

"Alternate living facility (ALF)" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and

room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapter 70.128 RCW.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living under chapter 18.20 RCW.

(3) Adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465 are licensed facilities that provides their residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapter 18.20 RCW.

(5) ((~~Division of~~)) Developmental disabilities (((~~DDD~~))) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on the size, a ((~~DDD~~)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

"Authorization date" means the date payment begins for long-term care services described in WAC 388-106-0045.

"CARE assessment" means the evaluation process defined in chapter 388-106 WAC used by a department designated social services worker or a case manager to determine the client's need for long-term care services.

"Clothing and personal incidentals (CPI)" means the cash payment issued by the department for clothing and personal items for individuals living in an ALF described in WAC ((~~388-478-0045~~)) 182-515-1500 or medical institution described in WAC ((~~388-478-0040~~)) 182-513-1300.

"Community options program entry system (COPES)" means a medicaid home and community based (HCB) waiver program described in chapter 388-106 WAC that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility (ALF).

"Community spouse (CS)" means a person who:

(1) Does not reside in a medical institution; and

(2) Is legally married to a client who resides in a medical institution or receives services from a home and community-based (HCB) waiver program. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Community spouse excess shelter" means the excess shelter standard is used to calculate whether a community spouse qualifies for the community spouse maintenance allowance because of high shelter costs. The federal maximum standard that is used to calculate the amount is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse income and family allocation" means:

(1) The community spouse income standard is used when there is a community spouse. It is used when determining the total allocation for the community spouse from the institutional spouse's income.

(2) The family allocation income standard is used when a dependent resides with the community spouse. This amount is deducted from an institutional spouse's payment for their cost of care to help support the dependent. The federal maximum standard that is used to calculate the amount can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse maintenance allocation" means an amount deducted from an institutional spouse's payment toward their cost of care in order for the community spouse to have enough income to pay their shelter costs. This is a combination of the community spouse income allocation and the community spouse excess shelter calculation. The federal maximum standard that is used to calculate the amount can be found at: http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse resource allocation (CSRA)" means the resource amount the community spouse is allowed. A community spouse resource evaluation is completed to determine if the standard is more than the state standard up to the federal community spouse transfer maximum standard.

"Community spouse resource evaluation" means a review of the couple owned at the start of the current period of institutional status. This review may result in a resource standard for the community spouse that is higher than the state standard.

"Community spouse transfer maximum" means the federal maximum standard that is used to determine the community spouse resource allocation (CSRA). This standard is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Developmental disabilities administration (DDA)" means an administration within aging and disability services (ADS) of department of social and health services (DSHS) supporting individuals with developmental disabilities.

"((~~DDD~~)) DDA waiver" means medicaid waiver programs described in chapter 388-845 WAC that provide home and community-based services as an alternative to an intermediate care facility for the intellectually disabled (ICF-ID) to persons determined eligible for services from ((~~DDD~~)) DDA.

"Dependent" means an individual who is financially dependent upon another for his well being as defined by financial responsibility regulations for the program. For the purposes of long-term care, rules allow allocation in post eligibility to a dependent. If the dependent is eighteen years or older and being claimed as a dependent for income tax pur-

poses, a dependent allocation can be considered. This can include an adult child, a dependent parent or a dependent sibling.

"Equity" means the equity of real or personal property is the fair market value (see definition below) less any encumbrances (mortgages, liens, or judgments) on the property.

"Exception to rule (ETR)" means a waiver by the secretary's designee to a department policy for a specific client experiencing an undue hardship because of the policy. The waiver may not be contrary to law.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market at the time of transfer or assignment.

"Federal benefit rate (FBR)" means the basic benefit amount the Social Security administration (SSA) pays to clients who are eligible for the supplemental security income (SSI) program.

"Home and community based services" (HCBS) means services provided in the home or a residential setting to individuals assessed by the department.

"Home and community based (HCB) waiver programs" means section 1915(c) of the Social Security Act enables states to request a waiver of applicable federal medicaid requirements to provide enhanced community support services to those medicaid beneficiaries who would otherwise require the level of care provided in a hospital, nursing facility or intermediate care facility for the intellectually disabled (ICF-ID).

"Initial eligibility" means part one of institutional medical eligibility for long-term care services. Once resource and general eligibility is met, the gross nonexcluded income is compared to three hundred percent of the federal benefit rate (FBR) for a determination of CN or MN coverage.

"Institutional services" means services paid for by medicaid or state funds and provided in a medical institution, through a home and community based (HCB) waiver or program of all-inclusive care for the elderly (PACE).

"Institutional status" means what is described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized spouse" means legally married person who has attained institutional status as described in chapter ((~~388-513~~)) 182-513 WAC, and receives services in a medical institution or from a home and community based waiver program described in chapters ((~~388-513~~)) 182-513 and ((~~388-515~~)) 182-515 WAC. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps as a personal needs allowance or that is allocated to a spouse or dependent family member who lives in the client's home. (See community spouse maintenance allocation and community spouse income and family allocation.)

"Medicaid personal care (MPC)" means a medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home or in a residential facility. Financial eligibility is based on a client receiving a noninstitutional aged, blind, disabled (ABD) categorically needy (CN) medical program or receiving a modified adjusted gross income (MAGI) based medicaid program.

"Noninstitutional medical assistance" means any medical benefits or programs not authorized under chapter ((~~388-513~~)) 182-513 or ((~~388-515~~)) 182-515 WAC. The exception is WAC ((~~388-513-1305~~)) 182-513-1305 noninstitutional SSI-related clients living in an ALF.

"Participation" means the amount a client is responsible to pay each month toward the total cost of personal care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income. Individuals receiving services in an ALF pay room and board in addition to calculated participation. Participation is the result of the post-eligibility process used in institutional and HCB waiver eligibility.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services due to asset transfers.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for long-term care clients who live in a medical institution or alternate living facility, or at home.

"Short stay" means a person who has entered a medical institution but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Spousal impoverishment" means financial provisions to protect income and assets of the noninstitutional (community spouse) through income and resource allowances. The spousal allocation process is used to discourage the impoverishment of a spouse due to the need for LTC services by their husband or wife. That law and those that have extended and/or amended it are referred to as spousal impoverishment legislation. (Section 1924 of the Social Security Act.)

"State spousal resource standard" means minimum resource standard allowed for a community spouse. (See community spouse resource transfer maximum.)

"Swing bed" means a bed in a critical access hospital that is contracted to be used as either a hospital or a nursing facility bed based on the need of the individual.

"Third party resource (TPR)" means a resource where the purpose of the payment is for payment of assistance of daily living or medical services or personal care. Third party resources are described in WAC 182-501-0200. The department is considered the payer of last resort as described in WAC 182-502-0100.

"Transfer of a resource or asset" means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(1) An intentional act that changes ownership or title; or

(2) A failure to act that results in a change of ownership or title.

"Transfer date for real property or interest in real property" means:

(1) The date of transfer for real property is the day the deed is signed by the grantor if the deed is recorded; or

(2) The date of transfer for real property is the day the signed deed is delivered to the grantee.

"Transfer month" means the calendar month in which resources were legally transferred.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs. Clients who are denied or terminated from LTC services due to a transfer of asset penalty or having excess home equity may apply for an undue hardship waiver based on criteria described in WAC ((~~388-513-1367~~)) 182-513-1367.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount;

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both;

(5) Dependent allowance veteran's payments made to, or on behalf of, spouses of veterans or children regardless of their ages or marital status. Any portion of a veteran's payment that is designated as the dependent's income is countable income to the dependent; or

(6) Special monthly compensation (SMC). Extra benefit paid to a veteran in addition to the regular disability compensation to a veteran who, as a result of military service, incurred the loss or loss of use of specific organs or extremities.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under medicaid. In Washington state, home and community based (HCB) waiver programs are authorized by the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA), or home and community services (HCS).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1305 Determining eligibility for SSI-related noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC ((~~388-478-0045~~)) 182-515-1500 for the personal needs allowance (PNA) amount that applies in this rule.

(1) The eligibility criteria for noninstitutional medical assistance in an ALF follows SSI-related medical rule described in chapter 182-512 WAC ((~~182-512-0050 through 182-512-0960~~)) with the exception of the higher medical standard based on the daily rate described in subsection (3) of this section.

(2) Alternate living facilities ((~~(AFH) [(ALF)]~~)) (ALF) include the following:

(a) An adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapters 70.128 RCW and 388-76 WAC;

(b) An adult residential care facility (ARC) (formally known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(c) An adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465. These are licensed facilities that provide its residents with twenty-four hour residential care for impairments related to mental illness;

(d) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(e) ((~~Division of~~)) Developmental disabilities ((~~(DDD)~~)) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on size of a ((~~DDD~~)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or a boarding home under chapter 18.20 RCW. Group home

means a residence that is licensed as either an assisted living facility or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider; and

(f) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

(3) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program has two steps:

(a) The gross nonexcluded monthly income cannot exceed the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(b) The countable income cannot be greater than the department contracted daily rate times thirty-one days, plus the thirty-eight dollars and eighty-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300.

(4) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility daily rate times thirty one days, plus the thirty-eight dollars and eight-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300. Follow MN rules described in chapter 182-519 WAC.

(5) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who is SSI-related as described in WAC 182-512-0050, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 (1); and

(b) The client's nonexcluded income does not exceed the CN standard described in subsection (3) of this section. SSI-related program as described in chapter 182-512 WAC.

(6) The department approves MN noninstitutional medical assistance for a period of months described in chapter 182-504 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 (1); and

(b) The client satisfies any spenddown liability as described in chapter 182-519 WAC.

(7) ((~~The department determines eligibility for a cash grant for individuals residing in an alternate living facility using the following program rules:~~

~~(a) WAC 388-400-0005 temporary assistance for needy families (TANF);~~

~~(b) WAC 388-400-0060 aged, blind, disabled (ABD) cash benefit;~~

~~(c) WAC 388-400-0030 refugee assistance.~~

~~(8) The~~)) A client ((~~described in subsection (7)~~)) residing in an adult family home (AFH) ((~~receives~~)) receiving a grant based on a payment standard described in WAC 388-478-0033 due to an obligation to pay shelter costs to the adult family home. The client keeps a CPI/PNA in the amount of thirty-eight dollars and eighty-four cents described in WAC ((~~388-478-0045~~)) 182-515-1500 and pays the remainder of the grant to the adult family home as room and board.

(((~~(9) The client described in subsection (7) residing in an ALF described in subsections (2)(b), (c), (d), (e), (f) or (g) (all nonadult family home residential settings) keeps the thirty-eight dollars and eighty-four cents CPI amount based on WAC 388-478-0045.~~

~~(10)~~)) (8) The client described in subsection (3) of this section and receiving medicaid personal care (MPC) from the department keeps sixty-two dollars and seventy-nine cents as a PNA and pays the remainder of their income to the ALF for room and board and personal care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1315 Eligibility for long-term care (institutional, home and community based (HCB) waiver, and hospice) services. ((~~This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded long-term care services program described in subsection (11).~~

~~(1) To be eligible for long-term care (LTC) services described in this section, a client must:~~

~~(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505 (2) and (3)(a) through (g);~~

~~(b) Attain institutional status as described in WAC 388-513-1320;~~

~~(c) Meet functional eligibility described in chapter 388-106 WAC for home and community services (HCS) waiver and nursing facility coverage; or~~

~~(d) Meet criteria for division of developmental disabilities (DDD) assessment under chapter 388-828 WAC for DDD waiver or institutional services;~~

~~(e) Not have a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365;~~

~~(f) Not have equity interest in their primary residence greater than the home equity standard described in WAC 388-513-1350; and~~

~~(g) Must disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 388-561 WAC.~~

~~(i) This is required for all institutional or waiver services and includes those individuals receiving supplemental security income (SSI).~~

~~(ii) A signed and completed eligibility review for long term care benefits or application for benefits form can be accepted for SSI individuals applying for long-term care services.~~

~~(2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:~~

~~(a) Be related to the supplemental security income (SSI) program as described in WAC 182-512-0050 (1), (2) and (3) and meet the following financial requirements, by having:~~

(i) Gross nonexcluded income described in subsection (8)(a) that does not exceed the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); and

(ii) Countable resources described in subsection (7) that do not exceed the resource standard described in WAC 388-513-1350; or

(b) Be approved and receiving aged, blind, or disabled cash assistance described in WAC 388-400-0060 and meet citizenship requirements for federally funded medicaid described in WAC 388-424-0010; or

(c) Be eligible for CN apple health for kids described in WAC 182-505-0210; or CN family medical described in WAC 182-505-0240; or family and children's institutional medical described in WAC 182-514-0230 through 182-514-0260. Clients not meeting the citizenship requirements for federally funded medicaid described in WAC 388-424-0010 are not eligible to receive waiver services. Nursing facility services for noncitizen children require prior approval by aging and disability services administration (ADSA) under the state funded nursing facility program described in WAC 182-507-0125; or

(d) Be eligible for the temporary assistance for needy families (TANF) program as described in WAC 388-400-0005. Clients not meeting disability or blind criteria described in WAC 182-512-0050 are not eligible for waiver services.

(3) The department allows a client to reduce countable resources in excess of the standard. This is described in WAC 388-513-1350.

(4) To be eligible for waiver services, a client must meet the program requirements described in:

(a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or

(b) WAC 388-515-1510 through 388-515-1514 for DDD waivers.

(5) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC; and

(b) Be eligible for a noninstitutional categorically needy program (CN) if not residing in a medical institution thirty days or more; or

(c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 through 388-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the 300 percent of the FBR or clients with a community spouse); or

(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(e) Be eligible for institutional CN if residing in a medical institution thirty days or more.

(6) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for MN children's medical program described in WAC 182-514-0230, 182-514-0255, or 182-514-0260; or

(b) Related to the SSI-program as described in WAC 182-512-0050 and meet all requirements described in WAC 388-513-1395; or

(c) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or

(d) Eligible for the MN SSI-related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.

(e) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 388-513-1395.

(7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resource eligibility and standards described in WAC 388-513-1350; and

(b) Evaluates the transfer of assets as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365.

(8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(9) A client who meets the requirements of the CN program is approved for a period of up to twelve months.

(10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(11) The department determines eligibility for state funded programs under the following rules:

(a) A client who is eligible for ABD cash assistance program described in WAC 388-400-0060 but is not eligible for federally funded medicaid due to citizenship requirements receives MCS medical described in WAC 182-508-0005. A client who is eligible for MCS may receive institutional services but is not eligible for hospice or HCB waiver services.

(b) A client who is not eligible for ABD cash assistance but is eligible for MCS coverage only described in WAC 182-508-0005 may receive institutional services but is not eligible for hospice or HCB waiver services.

(c) A noncitizen client who is not eligible under subsections (11)(a) or (b) and needs long-term care services may be eligible under WAC 182-507-0110 and 82-507-0125. This program must be pre-approved by aging and disability services administration (ADSA).

(12) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is under the age of twenty-one at the time of application; or

~~(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or~~

~~(d) Is at least sixty-five years old.~~

~~(13) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.~~

~~(14) If an individual under age twenty one is not eligible for medicaid under SSI-related in WAC 182-512-0050 or ABD cash assistance described in WAC 388-400-0060 or MCS described in WAC 182-508-0005, consider eligibility under WAC 182-514-0255 or 182-514-0260.~~

~~(15) Noncitizen clients under age nineteen can be considered for the apple health for kids program described in WAC 182-505-0210 if they are admitted to a medical institution for less than thirty days. Once a client resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 182-514-0260 and must be preapproved for coverage by ADSA as described in WAC 182-507-0125.~~

~~(16) Noncitizen clients not eligible under subsection (15) of this section can be considered for LTC services under WAC 182-507-0125. These clients must be preapproved by ADSA.~~

~~(17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:~~

~~(a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;~~

~~(b) For clients receiving HCS CN waiver services see WAC 388-515-1509;~~

~~(c) For clients receiving DDD CN waiver services see WAC 388-515-1514; or~~

~~(d) For TANF related clients residing in a medical institution see WAC 182-514-0265.~~

~~(18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN medicaid. These groups are described in WAC 182-512-0880.~~)) This section describes how the medicaid agency or its designee determines a client's eligibility for Washington apple health (WAH) long-term care coverage for clients residing in a medical institution, receiving home and community based waiver services, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under state-funded medical care services (MCS) program and the state funded long-term care services program.

This chapter includes the following sections;

(1) WAC 182-513-1316, General eligibility requirements for WAH long-term care programs.

(2) WAC 182-513-1317, Income and resource criteria for an institutionalized client.

(3) WAC 182-513-1318, Income and resource criteria for home and community based (HCB) waiver programs and hospice clients.

(4) WAC 182-513-1319, State-funded programs for non-citizen clients.

NEW SECTION

WAC 182-513-1316 General eligibility requirements for WAH long-term care programs. (1) To be eligible for long-term care (LTC) services, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505;

(b) Attain institutional status as described in WAC 182-513-1320;

(c) Meet the functional eligibility described in:

(i) Chapter 388-106 WAC for a home and community services (HCS) waiver or nursing facility coverage; or

(ii) Chapter 388-828 WAC for DDA waiver or institutional services; and

(d) Meet either:

(i) SSI-related WAH criteria as described in WAC 182-512-0050; or

(ii) MAGI-based WAH criteria as described in WAC 182-503-0510(2). A client who is eligible for MAGI-based WAH is not subject to the provisions described in subsection (2) of this section.

(2) An SSI-related client, including supplemental security income (SSI) recipients, who needs LTC services must also:

(a) Not have a penalty period of ineligibility as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

(b) Not have equity interest in their primary residence greater than the home equity standard described in WAC 182-513-1350;

(c) Disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 182-516 WAC.

(3) An SSI recipient must submit a signed health care coverage application form attesting to the provisions described in subsection (2) of this section. A signed and completed eligibility review for long-term care benefits can be accepted for SSI clients applying for long-term care services.

(4) To be eligible for WAH LTC waiver services, a client must also meet the program requirements described in:

(a) WAC 182-515-1505 through 182-515-1509 for COPES, New Freedom PACE, and WMIP services; or

(b) WAC 182-515-1510 through 182-515-1514 for DDA waivers.

(5) A client who is eligible for categorically needy WAH coverage is certified for twelve months.

(6) A client who is eligible for medically needy WAH coverage is approved for a period of months described in WAC 182-513-1395(6) for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(7) The medicaid agency or its designee determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

NEW SECTION

WAC 182-513-1317 Income and resource criteria for an institutionalized client. (1) This section provides an overview of the income and resource eligibility rules for a client who lives in an institutional setting. The term "institution" is defined in WAC 182-500-0050.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)). A client's gross income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related WAH LTC client under the medically needy (MN) program, the agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Disregards income as described in WAC 182-513-1345; and

(d) Follows the income standards and eligibility rules described in WAC 182-513-1395.

(4) To be resource eligible under the SSI-related WAH LTC CN or MN program, the client must:

(a) Meet the resource eligibility requirements and standards described in WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363 or 182-513-1364;

(c) Disclose to the state any interest the client or the client's spouse has in an annuity and meet the annuity requirements described in chapter 182-516 WAC.

(5) The agency or its designee allows an institutionalized client to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

(6) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 182-513-1320; and

(b) Is under the age of twenty-one at the time of application; or

(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or

(d) Is at least sixty-five years old.

(7) To determine CN or MN income eligibility for a MAGI-based WAH LTC client, the medicaid agency or its designee follows the rules described in WAC 182-514-0230 through 182-514-0265.

(8) There is no asset test for MAGI-based WAH LTC programs as described in WAC 182-514-0245.

(9) The agency or its designee determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For SSI-related WAH clients residing in a medical institution see WAC 182-513-1380;

(b) For MAGI-based WAH clients residing in a medical institution see WAC 182-514-0265. Clients who are eligible for the MAGI-based WAH adult medical program described in WAC 182-505-0250 are not required to contribute toward the cost of care. Nursing home care is included in the alternative benefit plan scope of care for these clients.

NEW SECTION

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice clients. (1) This section provides an overview of the income and resource eligibility rules for a client to be eligible for a home and community based (HCB) waiver program or the Washington apple health (WAH) hospice program.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) waiver client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross non excluded income to:

(i) The special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); or

(ii) For home and community based (HCB) service programs authorized by aging and long-term supports administration (ALTSA), a higher standard is determined following the rules described in WAC 182-514-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A client who receives MAGI-based WAH is not eligible for HCB waiver services unless found eligible based on program rules in chapter 182-515 WAC.

(4) There is no WAH HCB waiver medically needy program.

(5) To be resource eligible under the SSI-related WAH LTC CN waiver programs, the client must:

(a) Meet the resource eligibility requirements and standards described in WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

(c) Disclose to the state any interest the client or the client's spouse has in an annuity and meet the annuity requirements described in chapter 182-516 WAC.

(6) The agency or its designee allows an HCB waiver client to use verified unpaid medical expenses to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

(7) The agency or its designee determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For clients receiving HCS CN waiver services see WAC 182-515-1509;

(b) For clients receiving DDA CN waiver services see WAC 182-515-1514.

(8) HCB waiver clients who are "deemed eligible" for SSI benefits as described in WAC 182-512-0880 do not pay service participation toward their cost of personal care. Clients living in a residential setting do pay room and board as described in WAC 182-515-1505 through 182-515-1509 or 182-515-1514.

(9) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC governing client eligibility for hospice care; and

(b) Be eligible for a noninstitutional CN program if not residing in a medical institution thirty days or more.

(10) A client who is not eligible for a noninstitutional CN program who needs hospice care is eligible for the WAH hospice program if they meet the following criteria:

(a) Meet the hospice program requirements described in chapter 182-551 WAC; and

(b) Reside at home and would be eligible for coverage by using home and community services waiver rules described in WAC 182-515-1505 through 182-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the three hundred percent of the FBR or clients with a community spouse); or

(c) Receive WAH HCBS waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(d) Be eligible for institutional CN if residing in a medical institution (including a hospice care center) for thirty days or more.

(11) To be eligible for hospice services under the MN program, a client must be:

(a) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or

(b) Eligible for the MN SSI-related program described in WAC 182-513-1305 for hospice clients not receiving HCBS waiver services who reside in an alternate living facility.

(c) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 182-513-1395.

NEW SECTION

WAC 182-513-1319 State-funded programs for noncitizen clients. (1) This section describes the programs that are available for noncitizen clients who do not meet the citizenship criteria described in WAC 182-503-0530 to be eligible for federally funded Washington apple health (WAH) coverage.

(2) Lawfully residing noncitizen clients who need nursing facility care or care in an alternate living facility may receive long-term care (LTC) coverage if the client meets the eligibility and incapacity criteria of the medical care services (MCS) program described in WAC 182-508-0005.

(3) Clients who receive MCS coverage are not eligible for home and community based (HCB) waiver programs or hospice care.

(4) Noncitizen clients under the age of nineteen who are eligible for the WAH for kids program described in WAC 182-505-0210 are eligible for LTC services if the client is admitted to a medical institution for less than thirty days. Once the client resides or is likely to reside in a medical institution for thirty days or more, the medicaid agency or its designee determines eligibility under WAC 182-514-0260, subject to being preapproved for coverage by aging and long-term supports administration (ALTSA) as described in WAC 182-507-0125.

(5) Noncitizen clients age nineteen or older may be eligible for the state-funded long-term care services WAH program described in WAC 182-507-0125. These clients must be preapproved by ALTSA as the program has enrollment limits. When the program is full, a client who needs LTC services is placed on a waiting list for services. Such an individual is not eligible for WAH waiver programs described in chapter 182-515 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). This section describes income the department considers available when determining an SSI-related single client's eligibility for LTC services (institutional, waiver or hospice).

(1) Refer to WAC ((~~388-513-1330~~)) 182-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for SSI-related LTC services:

(a) WAC 182-512-0600 Definition of income;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-514-0840(3) Self-employment income-allowable expenses;

(f) WAC ((~~388-513-1315~~)) 182-513-1315(15), Eligibility for long-term care (institutional, waiver, and hospice) services; and

(g) WAC ((~~388-450-0155, 388-450-0156, 388-450-0160~~)) 182-512-0785, 182-512-0790, 182-512-0795, and 182-509-0155 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 182-512-0600 Definition of income SSI-related medical;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-512-0840(3) Self-employment income-allowance expenses;

(f) WAC 182-512-0960, SSI-related medical clients; and

(g) WAC ((~~388-513-1315~~)) 182-513-1315, Eligibility for long-term care (institutional, waiver, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a court order.

(4) For the determination of eligibility only, if available income described in subsection((~~s~~)) (2)(a) through (d) of this section minus income exclusions described in WAC ((~~388-513-1340~~)) 182-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; ((~~and~~))

(c) Considers one-half of all community income available to the institutionalized client((~~.~~)); and

(d) If the total of ((~~subsection (4)~~)) (c) of this subsection plus the client's own income is over the SIL, follow subsection (2) of this section.

(5) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(6) The department considers income available to the client not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the stream of income to:

(a) The spouse; or

(b) A trust for the benefit of their spouse.

((~~(8)~~)) (7) The department evaluates the transfer of a resource described in subsection (5) of this section according to WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365 to determine whether a penalty period of ineligibility is required.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exception described in subsection (31) of this section.

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC) for twelve months after the month of receipt;

(3) Native American benefits excluded by federal statute (refer to WAC ((~~388-450-0040~~)) 182-512-0700);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental security income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) ((~~Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution~~)) Education benefits described in WAC 182-509-0335;

(10) Child support payments received from an absent parent for a child living in the home are considered the income of the child;

(11) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(12) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(13) Assistance (other than wages or salary) received under the Older Americans Act;

(14) Assistance (other than wages or salary) received under the foster grandparent program;

(15) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(16) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(17) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(18) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(19) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(20) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(21) Payments made under the Energy Employee Occupational Compensation Program Act of 2000, (EEOICPA) Pub. L. 106-398;

(22) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(23) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(24) Payments made from *Susan Walker v. Bayer Corporation, et, al*., 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(25) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(26) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(27) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(28) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(29) Interest or dividends received by the client is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bond, or savings accounts. Institutional status is defined in WAC ((~~388-513-1320~~)) 182-513-1320;

(30) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(31) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (32) of this section;

(32) Benefits described in subsection (31)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC ((~~388-513-1340~~)) 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (4) of this section.

(4) Benefits described in subsection (3)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (9) through (12) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (4) of this section applies.

(2) Effective January 1, 2012, if an individual purchases a qualified long-term care partnership policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department allows the individual with the long-term care partnership policy to retain a higher resource amount based on the dollar amount paid out by a partnership policy. This is described in WAC ((~~388-513-1400~~)) 182-513-1400.

(3) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(4) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(5) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the department applies subsection (1)(b) of this section for a couple.

(6) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(7) The department applies the following rules when determining available resources for LTC services:

(a) WAC 182-512-0300, Resource eligibility;

(b) WAC 182-512-0250, How to determine who owns a resource; and

(c) WAC ((~~388-470-0060~~)) 182-512-0260, Resources of an alien's sponsor.

(8) For LTC services the department determines a client's countable resources as follows:

(a) The department determines countable resources for SSI-related clients as described in chapter 182-512 WAC ((~~182-512-0350 through 182-512-0550~~)) and resources excluded by federal law with the exception of:

(i) WAC 182-512-0550 pension funds owned by an:

(((~~I~~))) (A) Ineligible spouse. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the IRS code; or

(((~~II~~))) (B) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(ii) WAC 182-512-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006, and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC ((~~388-513-1367~~)) 182-513-1367. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012, and on January 1st of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011, and each year thereafter, see ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) A vehicle not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (3), (6), and (9)(a) or (b) of this section apply, but not if subsection (4) or (5) of this section apply.

(d) For an SSI-related client, excess resources are reduced:

(i) In an amount equal to incurred medical expenses such as:

(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and medicare;

(B) Medically necessary ((~~medical~~)) care recognized under state law, but not covered under the state's medicaid plan;

(C) Medically necessary ((~~medical~~)) care covered under the state's medicaid plan incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to.

(ii) As long as the incurred medical expenses:

(A) Were not incurred more than three months before the month of the medicaid application;

(B) Are not subject to third-party payment or reimbursement;

(C) Have not been used to satisfy a previous spend down liability;

(D) Have not previously been used to reduce excess resources;

(E) Have not been used to reduce client responsibility toward cost of care;

(F) Were not incurred during a transfer of asset penalty described in WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365; and

(G) Are amounts for which the client remains liable.

(e) Expenses not allowed to reduce excess resources or participation in personal care:

(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or assisted living facility is not a medical expense.

(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.

(f) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate (FBR).

(B) In a medical institution, excess resources and income must be under the state medicaid rate based on the number of days in the medical institution in the month.

(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to countable income, the combined total is less than the:

(A) State medical institution rate based on the number of days in the medical institution in the month, plus the amount of recurring medical expenses; or

(B) State hospice rate based on the number of days in the medical institution in the month plus the amount of recurring medical expenses, in a medical institution.

(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(9) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, the department adds together one-half the total amount of countable resources held in the name of:

(i) The institutionalized spouse; or

(ii) Both spouses.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(10) If subsection (9)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989, and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard may change annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see long-term care standards at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the first day of the month of the current period of institutional status, up to the amount described in subsection (10)(a) of this section; or

(ii) The state spousal resource standard of forty-eight thousand six hundred thirty-nine dollars (this standard may change every odd year on July 1st). This standard is based on the consumer price index published by the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(c) Resources are verified on the first moment of the first day of the month institutionalization began as described in WAC 182-512-0300(1).

(11) The amount of the spousal share described in subsection (10)(b)(i) of this section can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(12) The amount of allocated resources described in subsection (10) of this section can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in ((~~a fair~~)) an administrative hearing described in chapter ((~~388-02~~)) 182-526 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(13) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (6) or (14)(a), (b), or (c) of this section applies.

(14) A redetermination of the couple's resources as described in subsection (8) of this section is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status; or

(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a) of this section, if subsection (9)(b) of this section applies; or

(c) The institutionalized spouse does not transfer the amount described in subsection((~~s~~)) (10) or (12) of this section to the community spouse by either:

(i) The end of the month of the first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1363 Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. This section describes how the department evaluates asset transfers made on or after May 1, 2006, and their ((~~affect~~)) effect on LTC services. This applies to transfers by the client, spouse, a guardian or

through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

• Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003, and before May 1, 2006.

• Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006, on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

(2) The department does not apply a penalty period to transfers meeting the following conditions:

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in ((~~subsection (2)~~))(d) of this subsection;

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.

(iii) All assets transferred for less than fair market value have been returned to the client.

(iv) The denial of eligibility would result in an undue hardship as described in WAC ((~~388-513-1367~~)) 182-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided verifiable care that enabled the individual to remain in the home. A physician's statement of needed care is required; or

(iii) Brother or sister, who has:

(A) Equity in the home((~~,~~)); and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (2)(f) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) of

this section as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in ((~~subsection (8)~~)) (a) of this subsection becomes an available resource as of the first day of the following month.

(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (10)~~)) (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (7)(a), (b), and (c) of this section.

(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;

(a) We divide the penalty between the two spouses.

(b) If one spouse is no longer subject to a penalty (e.g., the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in ((~~subsection (1)~~)) (d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the client to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home; and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(f) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(2) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of institutional status, if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's ((~~waivered~~)) HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(3) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (2) of this section as the transfer of an asset without adequate consideration.

(4) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and

(d) The requirements in ((~~subsection (4)~~)) (c) of this ((~~section~~)) subsection do not apply to trusts described in WAC ((~~388-561-0100~~)) 182-516-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC ((~~388-513-1365~~)) 182-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in ((~~subsection (5)~~)) (a)(ii) of this subsection.

(6) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (6)(a) becomes an available resource as of the first day of the following month.

(7) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(8) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (8)~~)) (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (5)(a) and (b) and ((~~(8)~~))

(a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer meets the conditions described in ((~~subsection (1)~~)) (d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) of this section is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) of this section as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC ((~~388-561-0100~~)) 182-516-0100.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in ((~~subsection (6)~~)) (a)(ii) of this subsection.

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remains after an acquisition described in ((~~subsection (7)~~)) (a) of this subsection becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (((~~9~~))) (a) of this subsection is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following ((~~subsections (9)~~)) (a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC ((~~388-513-1365~~)) 182-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993, and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~)) (b)(ii) of this subsection.

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~)) (b)(ii) of this subsection.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1367 Hardship waivers for long-term care (LTC) services. Clients who are denied or terminated from LTC services due to a transfer of asset penalty (described in WAC ((~~388-513-1363, 388-513-1364 and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365), or having excess home equity (described in WAC ((~~388-513-1350~~)) 182-513-1350) may apply for an undue hardship waiver. Notice of the right to apply for an undue hardship waiver will be given whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

• Defines undue hardship;

• Specifies the approval criteria for an undue hardship request;

• Establishes the process the department follows for determining undue hardship; and

• Establishes the appeal process for a client whose request for an undue hardship is denied.

(1) When does undue hardship exist?

(a) Undue hardship may exist:

(i) When a transfer of an asset occurs between:

(A) Registered domestic partners as described in chapter 26.60 RCW; or

(B) Same-sex couples who were married in states and the District of Columbia where same-sex marriages are legal; and

(C) The transfer would not have caused a period of ineligibility if made between an opposite sex married couple under WAC ((~~388-513-1363~~)) 182-513-1363.

(ii) When a client who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian or attorney-in-fact, has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period; and

(iii) The client provides sufficient documentation to support their efforts to recover the assets or income; or

(iv) The client is unable to access home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350; and

(v) When, without LTC benefits, the client is unable to obtain:

(A) Medical care to the extent that his or her health or life is endangered; or

(B) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(2) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a client or restricts their lifestyle but does not seriously deprive him or her as defined in subsection (1)(a)(iii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the client; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the client.

((~~(d)~~)) (3) Undue hardship may exist under subsection (2)(b) and (c) of this section if DSHS has found evidence of financial exploitation.

((~~(3)~~)) (4) How is an undue hardship waiver requested?

(a) An undue hardship waiver may be requested by:

(i) The client;

(ii) The client's spouse;

(iii) The client's authorized representative;

(iv) The client's power of attorney; or

(v) With the consent of the client or their guardian, a medical institution, as defined in WAC ((~~182-500-0005~~)) 182-500-0050, in which an institutionalized client resides.

(b) Request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a client, then the client's name, address and telephone number must be included;

(iv) Be made within thirty days of the date of denial or termination of LTC services; and

(v) Returned to the originating address on the denial/termination letter.

((~~(4)~~)) (5) What if additional information is needed to determine a hardship waiver? ((~~(a)~~)) A written notice to the client is sent requesting additional information within fifteen days of the request for an undue hardship waiver. Additional time to provide the information can be requested by the client.

((~~(5)~~)) (6) What happens if my hardship waiver is approved?

(a) The department sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a client's situation that led to the approval of a hardship must be reported to the department ((~~by the tenth of the month following~~)) within thirty days of the change per WAC ((~~388-418-0007~~)) 182-504-0110.

((~~(6)~~)) (7) What happens if my hardship waiver is denied?

(a) The department sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice will have instructions on how to request an administrative hearing. The department must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

(((~~(7)~~))) (8) What statute or rules govern administrative hearings? (((~~(a)~~))) An administrative hearing held under this section is governed by chapters 34.05 RCW and ((~~chapter 388-02~~)) 182-526 WAC and this section. If a provision in this section conflicts with a provision in chapter ((~~388-02~~)) 182-526 WAC, the provision in this section governs.

(((~~(8)~~))) (9) Can the department revoke an approved undue hardship waiver? (((~~(a)~~))) The department may revoke approval of an undue hardship waiver if any of the following occur:

(((~~(i)~~))) (a) A client, or his or her authorized representative, fails to provide timely information and/or resource verifications as it applies to the hardship waiver when requested by the department per WAC ((~~388-490-0005 and 388-418-0007~~)) 182-503-0050 and 182-504-0120 or 182-504-0125;

(((~~(ii)~~))) (b) The lien or legal impediment that restricted access to home equity in excess of five hundred thousand dollars is removed; or

(((~~(iii)~~))) (c) Circumstances for which the undue hardship was approved have changed.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the department allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The department applies rules described in WAC ((~~388-513-1315~~)) 182-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.

(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (300% of the federal benefit rate (FBR)), if the client is not otherwise eligible for another non-institutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The department allocates nonexcluded income in the following order and the combined total of (((~~(4)~~))) (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following clients who live in a state veteran's home and receive a needs based veteran's pension in excess of ninety dollars:

(A) A veteran without a spouse or dependent child.

(B) A veteran's surviving spouse with no dependent children.

(ii) The difference between one hundred sixty dollars and the needs based veteran's pension amount for persons specified in ((~~subsection (4)~~)) (a)(i) of this ((~~section~~)) subsection who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a client living in a state veterans' home who does not receive a needs based veteran's pension;

(iv) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving ABD cash assistance.

(v) For all other clients in a medical institution the PNA is fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(5) The department allocates nonexcluded income after deducting amounts described in subsection (4) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is for the current month:

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance may change each January based on the consumer price index. Starting January 1, 2008, and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st; and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse: (((~~(A)~~))) For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the institutional client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income exemption.

(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under ((~~subsection (6)~~)) (b) of this subsection less the standard shelter allocation under ((~~subsection (6)~~)) (a) of this subsection. For the purposes of this rule:

(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(7) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) of this section only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(8) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

(9) Standards described in this section for long-term care can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1395 Determining eligibility for institutional or hospice services for individuals living in a medical institution under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.

(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5) of this section. In addition, a client must meet program requirements described in WAC ((~~388-513-1315~~)) 182-513-1315; and

(a) Be an SSI-related client with countable income as described in subsection (4)(a) of this section that is more than the special income level (SIL); or

(b) Be a child not described in ((~~subsection (1)~~)) (a) of this subsection with countable income as described in subsection (4)(b) of this section that exceeds the categorically needy (CN) standard for the ((~~children's medical~~)) Washington apple health (WAH) for kids program.

(2) For an SSI-related client, excess resources are reduced by medical expenses as described in WAC ((~~388-513-1350~~)) 182-513-1350 to the resource standard for a single or married individual.

(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:

(a) For an SSI-related client, the department determines countable resources per WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (3)~~)) (a) of this subsection, no determination of resource eligibility is required.

(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:

(a) For an SSI-related client, the department reduces available income as described in WAC ((~~388-513-1325 and 388-513-1330~~)) 182-513-1325 and 182-513-1330 by:

(i) Excluding income described in WAC ((~~388-513-1340~~)) 182-513-1340;

(ii) Disregarding income described in WAC ((~~388-513-1345~~)) 182-513-1345; and

(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (4)~~)) (a) of this subsection, the department:

(i) Follows the income rules described in WAC 182-505-0210 for the ((~~children's medical~~)) WAH for kids program; and

(ii) Subtracts the medical expenses described in this subsection ((~~(4)~~)).

(5) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1), is less than the department-contracted rate times the number of days residing in the facility the client:

(a) Is eligible for institutional or hospice services in a medical institution, and medical assistance;

(b) Is approved for twelve months; and

(c) Participates income and excess resources toward the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380.

(6) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1) is more than the department-contracted rate times the number of days residing in the facility the client:

(a) Is not eligible for payment of institutional services; and

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

(7) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 is more than the department contracted nursing facility rate based on the number of days the client is in the facility, but less than the private nursing rate plus the amount of medical expenses not used to reduce excess resources the client:

(a) Is eligible for nursing facility care only and is approved for a three or six month based period as described in chapter 182-519 WAC. This does not include hospice in a nursing facility; and

(i) Pays the nursing home at the current state rate;

(ii) Participates in the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380; and

(iii) Is not eligible for medical assistance or hospice services unless the requirements in subsection (6)(b) of this section is met.

(b) Is approved for medical assistance for a three or six month base period as described in chapter 182-519 WAC, if:

(i) No income and resources remain after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(ii) Medicaid certification is approved beginning with the first day of the base period.

(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income remaining after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(i) This process is known as spenddown and is described in WAC 182-519-0100.

(ii) Medicaid certification is approved on the day the spenddown is met.

(8) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 is more than the private nursing facility rate times the number of days in a month residing in the facility, the client:

(a) Is not eligible for payment of institutional services.

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long term care (LTC) partnership program, individuals who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the individual to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC ((~~388-513-1405~~)) 182-513-1405 Definitions.

(2) WAC ((~~388-513-1410~~)) 182-513-1410 What qualifies as a LTC partnership policy?

(3) WAC ((~~388-513-1415~~)) 182-513-1415 What assets can't be protected under the LTC partnership provisions?

(4) WAC ((~~388-513-1420~~)) 182-513-1420 Who is eligible for asset protection under a LTC partnership policy?

(5) WAC ((~~388-513-1425~~)) 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy that does not have exhausted benefits?

(6) WAC ((~~388-513-1430~~)) 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care?

(7) WAC ((~~388-513-1435~~)) 182-513-1435 Will Washington recognize a LTC partnership policy purchased in another state?

(8) WAC ((~~388-513-1440~~)) 182-513-1440 How many of my assets can be protected?

(9) WAC ((~~388-513-1445~~)) 182-513-1445 How do I designate a protected asset and what proof is required?

(10) WAC ((~~388-513-1450~~)) 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility?

(11) WAC ((~~388-513-1455~~)) 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death?

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1405 Definitions. For purposes of this section, the following terms have the meanings given them. Additional definitions can be found at chapter ((~~388-500~~)) 182-500 WAC and WAC ((~~388-513-1301~~)) 182-513-1301.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. Issuer as used in this chapter specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy described in Chapter 284-83 WAC.

"Long-term care services" means services received in a medical institution, or under a home and community based waiver authorized by home and community services (HCS) or ((~~division of~~)) developmental disabilities administration (DDA). Hospice services are considered long-term care services for the purposes of the long-term care partnership when medicaid eligibility is determined under chapter ((~~388-513 or 388-515~~)) 182-513 or 182-515 WAC.

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility described in WAC ((~~388-513-1315~~)) 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery described in chapter ((~~388-527~~)) 182-527 WAC, in up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

"Reciprocity Agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by an individual while residing in another state and that state has a reciprocity agreement with the state of Washington.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1415 What assets can't be protected under the LTC partnership provisions? The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust described in WAC ((~~388-561-0100~~)) 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as described in WAC ((~~388-561-0201~~)) 182-516-0201.

(3) Home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset (an example would be the home) is subject to estate recovery described in chapter ((~~388-527~~)) 182-527 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy in pay status? You are not eligible for LTC medicaid when the following applies:

(1) The income you have available to pay toward your cost of care described in WAC ((~~388-513-1380~~)) 182-513-1380, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver described in chapter ((~~388-515~~)) 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care? You must report changes described in WAC ((~~388-418-0005~~)) 182-418-0005 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the LTC partnership policy upon request by the department, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as protected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medic-

aid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility? (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, we will evaluate the transfer based on WAC ((~~388-513-1363~~)) 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets whose values are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death? Assets designated as protected prior to death are not subject to estate recovery for medical or LTC services paid on your behalf as described in chapter ((~~388-527~~)) 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof as described in chapter ((~~388-527~~)) 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

AMENDATORY SECTION (Amending WSR 13-03-096, filed 1/15/13, effective 1/15/13)

WAC 182-515-1500 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in ((~~the following facilities:~~

~~(a) Congregate care facilities (CCF);~~

~~(b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and~~

~~(c) Division of developmental disabilities (DDD) group home facilities~~)) alternative living facilities (ALF) described in WAC 182-513-1301.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1506 What are the general eligibility requirements for home and community based (HCB) services authorized by home and community services (HCS) and hospice? (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter 182-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC 182-500-0050, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in ((~~subsection (1)~~)) (a) of this subsection;

(e) Have attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in ((~~subsection (1)~~)) (a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365;

(i) Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1507 What are the financial requirements for home and community based (HCB) services authorized by home and community services (HCS) when you are eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program? (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);

(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250((~~;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid~~)).

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC ((~~388-515-1506~~)) 182-515-1506 (1)(g), you pay room and board up to the ((~~ADSA~~)) aging and disability services (ADS) room and board standard. The ((~~ADSA~~)) ADS room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If ((~~subsection (6)~~)) (a) of this subsection applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ((~~ADSA~~)) ADS room and board standard.

(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 and receiving SSI-related CN medicaid, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~ADSA~~)) ADS room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC ((~~388-478-0045~~)) 182-515-1500, which you keep for your PNA.

(8) Current resource and income standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltestandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services authorized by home and community services (HCS) and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1)? (1) If you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC ((~~388-513-1315 and 388-515-1506~~)) 182-513-1315 and 182-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) If you have resources over the standard allowed in WAC ((~~388-513-1350~~)) 182-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350 if you verify these expenses.

(4) You must meet the following income requirements:

(a) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); or

(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:

(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(ii) Net income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing gross nonexcluded income by:

(A) Medically needy (MN) disregards found in WAC ((~~388-513-1345~~)) 182-513-1345; and

(B) The average monthly nursing facility state rate is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012, and each year thereafter on October 1st. This standard will be updated annually in the long-term care standard section of the EAZ manual described at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(5) The department follows the rules in WAC ((~~388-515-1325, 388-513-1330, and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL, MNIL and FBR) for long-term care are found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC ((~~388-515-1508~~)) 182-515-1508? If you are only eligible for medicaid under WAC ((~~388-515-1508~~)) 182-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and ((~~any~~)) room and board ((~~deduction~~)) liability if residing in an alternate living facility is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income((~~.~~)):

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, plus;

(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) The amount allocated to the community spouse may be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2), and (3)(a) and (b) of this section; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (4)~~)) (a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (4)~~)) (b) of this subsection.

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltestandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1510 Division of developmental disabilities ((~~(DDD)~~)) administration (DDA) home and community based ((~~services~~)) (HCB) waivers. The four sections that follow describe the general and financial eligibility requirements for home and community based (HCB) waivers authorized by the ((~~division of~~)) developmental disabilities ((~~(DDD) home and community based services (HCBS) waivers~~)) administration (DDA).

(1) WAC ((~~388-515-1511~~)) 182-515-1511 describes the general eligibility requirements under the ((~~DDD HCBS~~)) DDA HCB waivers.

(2) WAC ((~~388-515-1512~~)) 182-515-1512 describes the financial requirements for the ((~~DDD~~)) DDA waivers if you are eligible for medicaid under the noninstitutional categorically needy program (CN).

(3) WAC ((~~388-515-1513~~)) 182-515-1513 describes the initial financial requirements for the ((~~DDD~~)) DDA HCB waivers if you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1).

(4) WAC ((~~388-515-1514~~)) 182-515-1514 describes the post eligibility financial requirements for the ((~~DDD~~)) DDA waivers if you are not eligible for medicaid under a categorically needy program CN listed in WAC ((~~388-515-1512~~)) 182-515-1512(1).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1511 What are the general eligibility requirements for waiver services under the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA) home and community based ((~~services (HCBS)~~)) (HCB) waivers? (1) This section describes the general eligibility requirements for waiver services under the ((~~DDD~~)) DDA home and community based ((~~services (HCBS)~~)) (HCB) waivers.

(2) The requirements for services for ((~~DDD HCBS~~)) DDA HCB waivers are described in chapter 388-845 WAC. The department establishes eligibility for ((~~DDD HCBS~~)) DDA HCB waivers. To be eligible, you must:

(a) Be an eligible client of the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA);

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(d) Have attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(e) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(f) Need waiver services as determined by your plan of care or individual support plan, and:

(i) Be able to live at home with waiver services; or

(ii) Live in a department contracted facility, which includes:

(A) A group home;

(B) Group training home;

(C) Child foster home, group home or staffed residential facility;

(D) Adult family home (AFH); or

(E) Adult residential care (ARC) facility.

(iii) Live in your own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider; and

(g) Be both medicaid eligible under the ((~~categorically needy program (CN)~~)) HCB waiver eligibility described in WAC 182-515-1510 and be approved for services by ((~~the division of developmental disabilities~~)) DDA.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1512 What are the financial requirements for the ((~~DDD~~)) DDA waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)? (1) You ((~~automatically~~)) meet income and resource eligibility for ((~~DDD~~)) DDA waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status((~~. These clients have medicaid eligibility determined and maintained by the Social Security Administration~~));

(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;

(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied((~~;~~

~~(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or~~

~~(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060~~)).

(2) If you are eligible for a CN medicaid program listed in subsection (1) ((~~above~~)) of this section, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services. You are responsible to pay room and board if residing in a residential setting.

(3) If you are eligible for a CN medicaid program listed in subsection (1) ((~~above~~)) of this section, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN medicaid program listed in subsection (1) of this section, you pay up to the ((~~ADSA~~)) aging and disability services (ADS) room and board standard ((~~described in WAC 388-515-1507~~)) based on the medically needy income level (MNIL) minus the sixty-two dollars and seventy-nine cents personal needs allowance (PNA). Room and board and long-term care standards are located at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(((~~a~~))) If you live in an ARC, AFH or ((~~DDD~~)) DDA group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ((~~ADSA~~)) ADS room and board standard. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for ((~~a~~)) the premium based medicaid program ((~~such as~~)), health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that ((~~CN-P~~)) CN program and pay the ADS room and board rate if residing in a residential ALF setting.

(6) If you are eligible for a CN medicaid program listed in subsection (1) of this section you are subject to equity interest in primary residence, annuity disclosure requirements and are not subject to a penalty period of ineligibility described in WAC 182-513-1315.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1513 How does the department determine if I am financially eligible for ((~~DDD~~)) DDA waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC ((~~388-515-1514~~)) 182-515-1514. To qualify, you must meet both the resource and income requirements.

(1) Resource limits are described in WAC ((~~388-513-1350~~)) 182-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) You are not subject to a transfer of asset penalty described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365.

(((~~d~~))) (3)Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(((~~3~~))) (4) Must disclose to the state any interest the applicant or spouse has in an annuity and meeting annuity requirements described in chapter 182-516 WAC.

(5) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC ((~~388-515-1325, 388-513-1330 and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(((~~4~~))) (6) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.

(((~~5~~))) (7) Current income and resources standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1514 How does the department determine how much of my income I must pay towards the cost of my ((~~DDD~~)) DDA waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or ((~~DDD~~)) DDA group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board rate described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)); http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in subsection (2) ((~~above~~)) of this section, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative plus;

(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) May be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) of this section for in home or subsection (2)(a) of this section in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (3)~~)) (a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (3)~~)) (b) of this subsection.

(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 and CN medicaid based on ABD criteria, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~ADSA~~)) ADS room and board standard described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)); http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; or

(c) When you live in an ARC or ((~~DDD~~)) DDA group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been

considered is called your total responsibility. You pay this amount to the ARC, AFH or ((~~DDD~~)) DDA group home provider.

WSR 14-02-090

EMERGENCY RULES

HEALTH CARE AUTHORITY

(Medicaid Program)

[Filed December 31, 2013, 8:58 a.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: **Medicaid Expansion Rules – Phase 5**, repealing WAC sections related to the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) and psychiatric indigent inpatient (PII) programs which are ending December 31, 2013; also striking references to ADATSA and PII in WAC sections that are being retained; correcting an income threshold percentage; and other miscellaneous changes related to implementation of the Affordable Care Act.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-503-0532, 182-503-0555, 182-503-0560, 182-504-0030, 182-504-0040, 182-504-0100, 182-506-0020, 182-508-0010, 182-508-0015, 182-508-0020, 182-508-0030, 182-508-0035, 182-508-0040, 182-508-0050, 182-508-0060, 182-508-0070, 182-508-0080, 182-508-0090, 182-508-0100, 182-508-0110, 182-508-0120, 182-508-0130, 182-508-0160, 182-508-0220, 182-508-0230, 182-508-0300, 182-508-0305, 182-508-0310, 182-508-0315, 182-508-0320, 182-508-0325, 182-508-0330, 182-508-0335, 182-508-0340, 182-508-0345, 182-508-0350, 182-508-0355, 182-508-0360, 182-508-0365, 182-508-0370, 182-508-0375, 182-509-0005, 182-509-0015, 182-509-0025, 182-509-0030, 182-509-0035, 182-509-0045, 182-509-0055, 182-509-0065, 182-509-0080, 182-509-0085, 182-509-0095, 182-509-0100, 182-509-0110, 182-509-0135, 182-509-0155, 182-509-0165, 182-509-0175, 182-509-0200, 182-509-0205, 182-509-0210, 182-509-0225, 182-523-0110, 182-523-0120 and 182-550-5125; and amending WAC 182-505-0120, 182-508-0005, 182-508-0150, 182-523-0100, 182-523-0130, 182-534-0100, 182-546-5550, 182-550-1200, 182-550-1700, 182-550-2521, 182-550-2650, and 182-550-6700.

Statutory Authority for Adoption: RCW 41.05.021; 3ESSB 5034 (sections 201, 204, 208, and 213, chapter 4, Laws of 2013); Patient Protection and Affordable Care Act (Public Law 111-148); 42 C.F.R. § 431, 435, and 457; and 45 C.F.R. § 155.

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; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 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: These emergency rules are necessary to meet the requirements in 3ESSB 5034, chapter 4, Laws of 2013, 63rd legislature, effective January 1, 2014.

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 12, Repealed 66.

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 12, Repealed 66.

Date Adopted: December 31, 2013.

Kevin M. Sullivan
Rules Coordinator

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-503-0532	Citizenship requirements for the medical care services (MCS) and ADATSA programs.
WAC 182-503-0555	Age requirement for MCS and ADATSA.
WAC 182-503-0560	Impact of fleeing felon status on eligibility for medical care services (MCS).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-504-0030	Medical certification periods for recipients of medical care services (MCS).
WAC 182-504-0040	Requirements for a midcertification review for medical care services (MCS).
WAC 182-504-0100	Changes of circumstances—Changes that must be reported by a recipient of medical care services (MCS).

AMENDATORY SECTION (Amending WSR 12-02-034, filed 12/29/11, effective 1/1/12)

WAC 182-505-0120 Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility. (1) Effective July 1, 2001, through December 31, 2013, a woman is eligible for categorically needy (CN) coverage

under the federally funded breast and cervical cancer treatment program (BCCTP) only when she:

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

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

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

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

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

(f) Meets residency requirements as described in WAC ((~~388-468-0005~~)) 182-503-0520;

(g) Meets Social Security number requirements as described in WAC ((~~388-476-0005~~)) 182-503-0515; ((~~and~~))

(h) Meets the requirements for citizenship or U.S. national status ((~~as defined in WAC 388-424-0001~~)) or "qualified alien" status as described in WAC ((~~388-424-0006 (1) or (4)~~)) 182-503-0535; and

(i) Meets the income and asset limits that are set by the CDC-BCCTP.

(2) A woman who is eligible for BCCTP on or before December 31, 2013, will continue to receive coverage after December 31, 2013, for the certification period if:

(a) She applies for Washington apple health (WAH) coverage on or before December 31, 2013; and

(b) She is determined to be not eligible for any other WAH pro-gram whose scope of services (as described in WAC 182-501-0060) includes breast and cervical cancer treatment.

(3) The WAH coverage referred to in subsection (2) of this section will continue uninterrupted for the certification period and will be under one of the following programs:

(a) A WAH program that the woman is determined eligible for, other than the state-only funded breast and cervical cancer treatment continuation program (BCCTCP); or

(b) BCCTCP if the woman is determined not eligible for any other WAH program.

(4) The certification period((~~s described in WAC 388-416-0015 (1), (4), and (6) apply to the BCCTP. Eligibility~~)) for ((~~medicaid continues throughout~~)) breast and cervical cancer treatment covered under subsection (2) of this section is the full course of treatment as certified by the CDC-BCCEDP.

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

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-506-0020 Assistance units for medical care services (MCS).

AMENDATORY SECTION (Amending WSR 12-19-051, filed 9/13/12, effective 10/14/12)

WAC 182-508-0005 Eligibility for medical care services. (1) ((~~An individual~~)) A person is eligible for Washington apple health (WAH) medical care services (MCS) ((~~benefits~~)) coverage to the extent of available funds if the ((~~individual:~~

~~(a) Completes an interview with the agency or its designee;~~

~~(b) Is incapacitated as required under WAC 182-508-0010 through 182-508-0120;~~

~~(c) Is at least eighteen years old or, if under eighteen, a member of a married couple;~~

~~(d) Is in financial need according to MCS' income and resource rules in chapter 182-509 WAC. The agency or the agency's designee determines who is in the individual's assistance unit according to WAC 182-506-0020;~~

~~(e) Meets the medical care services citizenship/alien status requirements under WAC 182-503-0532;~~

~~(f) Provides a Social Security number as required under WAC 388-476-0005;~~

~~(g) Resides in the state of Washington as required under WAC 182-503-0520;~~

~~(h) Reports changes of circumstances as required under WAC 182-504-0100; and~~

~~(i) Completes a midcertification review and provides proof of any changes as required under WAC 182-504-0040.~~

~~(2) An individual is not eligible for MCS benefits if the individual:~~

~~(a) Is eligible for temporary assistance for needy families (TANF) benefits.~~

~~(b) Refuses or fails to meet a TANF rule without good cause.~~

~~(c) Refuses to or fails to cooperate in obtaining federal aid assistance without good cause.~~

~~(d) Refuses or fails to participate in drug or alcohol treatment as required in WAC 182-508-0220.~~

~~(e) Is eligible for supplemental security income (SSI) benefits.~~

~~(f) Is an ineligible spouse of an SSI recipient.~~

~~(g) Refuses or fails to follow a Social Security Administration (SSA) program rule or application requirement without good cause and SSA denied or terminated the individual's benefits.~~

~~(h) Is fleeing to avoid prosecution of, or to avoid custody or confinement for conviction of, a felony, or an attempt to commit a felony as described in WAC 182-503-0560.~~

~~(i) Is eligible for a categorically needy (CN) medicaid program.~~

~~(j) Refuses or fails to cooperate with CN medicaid program rules or requirements.~~

~~(3) An individual who resides in a public institution and meets all other requirements may be eligible for MCS depending on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.~~

~~(a) An individual may be eligible for MCS if the individual is:~~

~~(i) A patient in a public medical institution; or~~

~~(ii) A patient in a public mental institution and is sixty-five years of age or older.~~

~~(b) An individual is not eligible for MCS when the individual is in the custody of or confined in a public institution~~

~~such as a state penitentiary or county jail, including placement:~~

~~(i) In a work release program; or~~

~~(ii) Outside of the institution including home detention.~~

~~(4)~~)) person is determined by the department of social and health services to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070.

(2) If an enrollment cap exists under WAC 182-508-0150, a waiting list of persons may be established.

AMENDATORY SECTION (Amending WSR 12-19-051, filed 9/13/12, effective 10/14/12)

WAC 182-508-0150 Enrollment cap for medical care services (MCS). (1) Enrollment in medical care services (MCS) coverage is subject to available funds.

(2) The agency may limit enrollment into MCS coverage by implementing an enrollment cap and ((~~waiting~~)) wait list.

(3) If ((~~an individual~~)) a person is denied MCS coverage due to an enrollment cap:

(a) The ((~~individual~~)) person is added to the MCS ((~~waiting~~)) wait list based on the date the ((~~individual~~)) person applied.

(b) Applicants with the oldest application date will be the first to receive an opportunity for enrollment when MCS coverage is available as long as the person remains on the MCS wait list.

(4) ((~~An individual~~)) A person is exempted from the enrollment cap and wait list rules when:

(a) MCS was terminated due to agency error;

(b) The ((~~individual~~)) person is in the thirty-day reconsideration period for incapacity reviews under WAC ((~~182-508-0160(4)~~)) 388-447-0110(4); ((~~or~~))

(c) The ((~~individual~~)) person is being terminated from a CN medical program and was receiving and eligible for CN coverage prior to the date a wait list was implemented and ((~~the following conditions are met:~~

~~(i) The individual met financial and program eligibility criteria for MCS at the time their CN coverage ended; and~~

~~(ii) The individual met the incapacity criteria for MCS at the time their CN coverage ended.~~

~~(d) The individual applied for medical coverage and an eligibility decision was not completed prior to the enrollment cap effective date.~~

~~(5) If the individual is sent an offer for MCS enrollment, the individual must submit a completed application no later than the last day of the month following the month of enrollment offer. The individual must reapply within this time period and subsequently be determined eligible before MCS coverage can begin. The individual must reapply and requalify even if the individual was previously determined eligible for MCS.~~

~~(6)~~)) at the time their CN coverage ended, the person met eligibility criteria to receive benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070; or

(d) The person applied for a determination by the department of social and health services (DSHS) to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070, but the determination was not completed prior to the enrollment cap effective date.

(5) The ((~~individual~~)) person is removed from the MCS wait list if the ((~~individual~~)) person:

(a) Is not a Washington resident;

(b) Is deceased;

(c) Requests removal from the wait list;

(d) ((~~Fails to submit an application after an enrollment offer is sent as described in subsection (5) of this section;~~

~~(e) Reapplies as described in subsection (5) of this section, but does not qualify for MCS; or~~

~~(f)~~)) Is found eligible for categorically or medically needy coverage; or

(e) Is no longer determined by DSHS to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-508-0010	Incapacity requirements for medical care services (MCS).
WAC 182-508-0015	Determining if an individual is incapacitated.
WAC 182-508-0020	Acceptable medical evidence.
WAC 182-508-0030	Required medical evidence.
WAC 182-508-0035	How severity ratings of impairment are assigned.
WAC 182-508-0040	PEP Step I—Review of medical evidence required for eligibility determination.
WAC 182-508-0050	PEP Step II—Determining the severity of mental impairments.
WAC 182-508-0060	PEP Step III—Determining the severity of physical impairments.
WAC 182-508-0070	PEP Step IV—Determining the severity of multiple impairments.
WAC 182-508-0080	PEP Step V—Determining level of function of mentally impaired individuals in a work environment.
WAC 182-508-0090	PEP Step VI—Determining level of function of physically impaired individuals in a work environment.
WAC 182-508-0100	PEP Step VII—Evaluating a client's capacity to perform relevant past work.

WAC 182-508-0110 PEP Step VIII—Evaluating a client's capacity to perform other work.

WAC 182-508-0120 Deciding how long a client is incapacitated.

WAC 182-508-0130 Medical care services—Limited coverage.

WAC 182-508-0160 When medical care services benefits end.

WAC 182-508-0220 How alcohol or drug dependence affects an individual's eligibility for medical care services (MCS).

WAC 182-508-0230 Eligibility standards for medical care services (MCS); aged, blind, or disabled (ABD); and Alcohol and Drug Addiction Treatment and Support Act (ADATSA).

WAC 182-508-0300 What is the purpose of this chapter?

WAC 182-508-0305 Detoxification—Covered services.

WAC 182-508-0310 ADATSA—Purpose.

WAC 182-508-0315 ADATSA—Covered services.

WAC 182-508-0320 ADATSA—Eligible individuals.

WAC 182-508-0325 When am I eligible for ADATSA treatment services?

WAC 182-508-0330 What clinical incapacity must I meet to be eligible for ADATSA treatment services?

WAC 182-508-0335 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse?

WAC 182-508-0340 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility?

WAC 182-508-0345 What are the responsibilities of the certified chemical dependency service provider in determining eligibility?

WAC 182-508-0350 What happens after I am found eligible for ADATSA services?

WAC 182-508-0355 What criteria does the certified chemical dependency service provider use to plan my treatment?

WAC 182-508-0360 Do I have to contribute to the cost of residential treatment?

WAC 182-508-0365 What happens when I withdraw or am discharged from treatment?

WAC 182-508-0370 What are the groups that receive priority for ADATSA services?

WAC 182-508-0375 ADATSA—Eligibility for state-funded medical care services (MCS).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-509-0005 MCS income—Ownership and availability.

WAC 182-509-0015 MCS income—Excluded income types.

WAC 182-509-0025 MCS income—Unearned income.

WAC 182-509-0030 MCS income—Earned income.

WAC 182-509-0035 MCS income—Educational benefits.

WAC 182-509-0045 MCS income—Employment and training programs.

WAC 182-509-0055 MCS income—Needs-based assistance from other agencies or organizations.

WAC 182-509-0065 MCS income—Gifts—Cash and noncash.

WAC 182-509-0080 MCS income—Self-employment income.

WAC 182-509-0085 MCS income—Self-employment income—Calculation of countable income.

WAC 182-509-0095 MCS income—Allocating income—General.

WAC 182-509-0100 MCS income—Allocating income—Definitions.

WAC 182-509-0110 MCS income—Allocating income to legal dependents.

WAC 182-509-0135 MCS income—Allocating income of an ineligible spouse to a medical care services (MCS) client.

WAC 182-509-0155 MCS income—Exemption from sponsor deeming for medical care services (MCS).

WAC 182-509-0165 MCS income—Income calculation.

WAC 182-509-0175 MCS income—Earned income work incentive deduction.

WAC 182-509-0200 MCS resources—How resources affect eligibility for medical care services (MCS).

WAC 182-509-0205 MCS resources—How resources count toward the resource limits for medical care services (MCS).

WAC 182-509-0210 MCS resources—How vehicles count toward the resource limit for medical care services (MCS).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-509-0225 Excluded resources for family medical programs.

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-523-0100 ((~~Medical extensions—Eligibility.~~)) Washington apple health—Health care extension. ((~~(1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for extended medical benefits when they become ineligible for their current medical program because the family receives:~~

~~(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or~~

~~(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.~~

~~(2) A family is eligible to receive extended medical benefits beginning the month after termination from TANF cash or family medical program for:~~

~~(a) Four months for a family described in subsection (1)(a) of this section; or~~

~~(b) Up to twelve months, in two six-month segments, for a family described in subsection (1)(b) of this section. For the purposes of this chapter, months one through six are the initial six-month extension period. Months seven through twelve are the second six-month extension period.~~

~~(3) A family member is eligible to receive six months of medical extension benefits as described in subsection (2)(b) of this section unless:~~

~~(a) The individual family member:~~

~~(i) Moves out of state;~~

~~(ii) Dies;~~

~~(iii) Becomes an inmate of a public institution;~~

~~(iv) Leaves the household; or~~

~~(v) Does not cooperate, without good cause, with the division of child support or with third-party liability requirements.~~

~~(b) The family:~~

~~(i) Moves out of state;~~

~~(ii) Loses contact with the department or the department does not know the whereabouts of the family; or~~

~~(iii) No longer includes a child as defined in WAC 388-404-0005(1).~~

~~(4) A family member is eligible to receive the second six months of medical extension benefits as described in subsection (2)(b) of this section unless:~~

~~(a) The family is no longer eligible for the reasons described in subsection (3)(a) or (b); or~~

~~(b) The individual family member is the caretaker adult who:~~

~~(i) Stops working or whose earned income stops;~~

~~(ii) Does not, without good cause, complete and return the completed medical extension report or otherwise provide the required income and child care information; or~~

~~(iii) Does not, without good cause, pay the billed premium amount for one month.~~

~~(5) A family described in subsection (3) will not receive medical extension benefits for any family member who has been found ineligible for TANF/SFA cash because of fraud in any of the six months prior to the medical extension period.~~

~~(6) For the purposes of this chapter, only individual family members that are eligible for medicaid are certified to receive medical benefits under this program.~~)) (1) A person who received coverage under the Washington apple health (WAH) parent and caretaker relative program (described in WAC 182-505-0240) in any three of the last six months is eligible for twelve months' extended health care coverage when ineligible for his or her current coverage due to increased earnings or hours of employment.

(2) A person remains eligible for WAH health care extension unless:

(a) The person:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution; or

(iv) Leaves the household.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the agency or its designee or the whereabouts of the family are unknown; or

(iii) No longer includes an eligible dependent child as defined in WAC 182-503-0565(2).

(3) When a person or family is determined ineligible for WAH coverage under subsection (2)(a) or (b) of this section during the health care extension period, the agency or designee redetermines eligibility for the remaining household members as described in WAC 182-504-0125 and sends written notice as described in chapter 182-518 WAC before WAH health care extension is terminated.

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-523-0130 Medical extension—Redetermination. (1) When the ((~~department~~)) agency or its designee determines the family or an individual family member is ineligible during the medical extension period, the ((~~department~~)) agency or its designee must determine if they are eligible for another medical program.

(2) Children are eligible for twelve month continuous eligibility beginning with the first month of the medical extension period.

(3) When a family reports a reduction of income, the family may be eligible for a family medical program instead of medical extension benefits.

(4) Postpartum and family planning extensions are described in WAC ((~~388-462-0015~~)) 182-505-0115.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-523-0110 Medical extensions—Reporting requirements.

WAC 182-523-0120 Medical extensions—Premiums.

AMENDATORY SECTION (Amending WSR 12-22-046, filed 11/2/12, effective 12/3/12)

WAC 182-534-0100 EPSDT. (1) Persons who are eligible for medicaid((~~, except those identified in subsection (4) of this section,~~)) are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 182-545-200.

(c) Services not otherwise covered under the medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 C.F.R. 441, Subpart B are met through a contract with transportation brokers throughout the state.

(((~~(4) Persons who are nineteen through twenty years of age who are eligible for any of the following programs that receive medicaid funding under the transitional bridge demonstration waiver allowed under section 1115 (a)(2) of the Social Security Act are not eligible for EPSDT services:~~

~~(a) Basic health;~~

~~(b) Medical care services; or~~

~~(c) Alcohol and Drug Addiction Treatment and Support Act (ADATSA).~~))

AMENDATORY SECTION (Amending WSR 11-17-059, filed 8/15/11, effective 8/15/11)

WAC 182-546-5550 Nonemergency transportation—Exclusions and limitations. (1) The following service categories cited in WAC ((~~388-501-0060~~)) 182-501-0060 are subject to the following exclusions and limitations:

(a) Adult day health (ADH) - Nonemergency transportation for ADH services is not provided through the brokers. ADH providers are responsible for arranging or providing transportation to ADH services.

(b) Ambulance - Nonemergency ambulance transportation is not provided through the brokers except as specified in WAC ((~~388-546-5200~~)) 182-546-5200 (1)(d).

(c) Family planning services - Nonemergency transportation is not provided through the brokers for clients that are enrolled only in TAKE CHARGE or family planning only services.

(d) Hospice services - Nonemergency transportation is not provided through the brokers when the health care service is related to a client's hospice diagnosis. See WAC ((~~388-551-1210~~)) 182-551-1210.

(e) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, with the exception of DME equipment that needs to be fitted to the client.

(f) Medical nutrition services - Nonemergency transportation is not provided through the brokers to pick up medical nutrition products.

(g) Medical supplies/equipment, nondurable (MSE) - Nonemergency transportation is not provided through the brokers for MSE services.

(h) Mental health services:

(i) Nonemergency transportation brokers generally provide one round trip per day to or from a mental health service. Additional trips for off-site activities, such as a visit to a recreational park, are the responsibility of the provider/facility.

(ii) Nonemergency transportation of involuntarily detained persons under the Involuntary Treatment Act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider. See WAC ((~~388-546-4000~~)) 182-546-4000.

(i) Substance abuse services - Nonemergency transportation is not provided through the brokers for substance abuse services for clients under the state-funded medical programs (medical care services program (MCS)). See WAC ((~~388-546-5200~~)) 182-546-5200(2).

(j) Chemical dependency services - Nonemergency transportation is not provided through the brokers to or from the following:

(i) Residential treatment;

(ii) Intensive inpatient;

(iii) Recovery house;

(iv) Long-term treatment;

(v) Information and assistance services, which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(2) The ((~~following medical assistance programs have limitations on trips:~~

~~(a)~~)) state-funded medical care services (MCS) program ((~~for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)~~)) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The ((~~department~~)) agency does pay for nonemergency transportation to and from medical services as specified in WAC ((~~388-501-0060~~)) 182-501-0060, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

(((~~(b) Transitional bridge waiver for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to and from medical services as covered in the transitional bridge waiver approved by the Centers for Medicare and Medicaid Services, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.~~))

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

WAC 182-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a ((~~client~~)) person eligible under a ((~~medical assistance~~)) Washington apple health (WAH) program that is paid by the ((~~department's~~)) agency's fee-for-services payment system must be within the scope of the ((~~client's medical assistance~~)) person's WAH program. Coverage restriction includes, but is not limited to the following:

(1) ((~~Clients~~)) Persons enrolled with the ((~~department's~~)) agency's managed care organization (MCO) plans are subject to the respective plan's policies and procedures for coverage of hospital services;

(2) ((~~Clients~~)) Persons covered by primary care case management are subject to the ((~~clients'~~)) persons' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for ((~~clients~~)) persons described in subsections (1) and (2) of this section, see WAC ((~~388-538-100.~~)) 182-538-100;

(4) ((~~Coverage for psychiatric indigent inpatient (PII) clients is limited to voluntary inpatient psychiatric hospital services, subject to the conditions and limitations of WAC 388-865-0217 and this chapter:~~

~~(a) Out-of-state health care is not covered for clients under the PII program; and~~

~~(b) Bordering city hospitals and critical border hospitals are not considered instate hospitals for PII program claims.~~

~~(5)~~)) Health care services provided by a hospital located out-of-state are:

(a) Not covered for ((~~clients~~)) persons eligible under the medical care services (MCS) program. However, ((~~clients~~)) persons eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and SCHIP ((~~clients~~)) persons without prior authorization, based on the medical necessity and utilization review standards and limits established by the ((~~department~~)) agency.

(ii) Nonemergency out-of-state care for medicaid and SCHIP ((~~clients~~)) persons when prior authorized by the ((~~department~~)) agency based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC ((~~388-501-0175~~)) 182-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and SCHIP clients based on authorization by a ((~~mental health division (MHD)~~)) division of behavioral health and recovery (DBHR) designee.

(((~~6~~))) (5) See WAC ((~~388-550-1100~~)) 182-550-1100 for hospital services for chemical-using pregnant (CUP) women((~~.~~));

(((~~7~~))) (6) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a ((~~MHD~~)) DBHR designee. See WAC ((~~388-550-2600.~~)) 182-550-2600;

(((~~8~~))) (7) For ((~~clients~~)) persons eligible for both medicare and medicaid (dual eligibles), the ((~~department~~)) agency pays deductibles and coinsurance, unless the ((~~client~~)) person has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the ((~~department~~)) agency pays for hospitalization for such ((~~clients~~)) persons subject to ((~~department~~)) agency rules. See also chapter ((~~388-502~~)) 182-502 WAC((~~.~~));

(((~~9~~))) (8) The ((~~department~~)) agency does not pay for covered inpatient hospital services for a ((~~medical assistance~~)) WAH client:

(a) Who is discharged from a hospital by a physician because the ((~~client~~)) person no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(((~~10~~))) (9) If the hospital's utilization review committee determines the ((~~client's~~)) person's stay is beyond the period of medical necessity, as described in subsection (((~~9~~))) (8) of this section, the hospital must:

(a) Inform the ((~~client~~)) person in a written notice that the ((~~department~~)) agency is not responsible for payment (42 C.F.R. 456);

(b) Comply with the requirements in WAC ((~~388-502-0160~~)) 182-502-0160 in order to bill the ((~~client~~)) person for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the ((~~department~~)) agency.

(((~~11~~))) (10) Other coverage restrictions, as determined by the ((~~department~~)) agency.

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

WAC 182-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services. (1) This section applies to the ((~~department's~~)) agency's

authorization and utilization review (UR) of inpatient and outpatient hospital services provided to ((~~medical assistance~~)) Washington apple health (WAH) clients receiving services through the fee-for-service program. For clients eligible under other ((~~medical assistance~~)) WAH programs, see chapter ((~~388-538~~)) 182-538 WAC for managed care organizations, ((~~chapters 388-800 and 388-810 WAC for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA),~~)) and chapter 388-865 WAC for mental health treatment programs coordinated through the ((~~mental health division~~)) department of social and health services' division of behavioral health and recovery or its designee((~~)~~)). See chapter ((~~388-546~~)) 182-546 WAC for transportation services.

(2) All hospital services paid for by the ((~~department~~)) agency are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The ((~~department~~)) agency will deny, recover, or adjust hospital payments if the ((~~department~~)) agency or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The ((~~department~~)) agency may perform one or more types of UR described in subsection (6) of this section.

(6) The ((~~department's~~)) agency's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee during a client's course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee prior to the provision of health care services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee following the provision of health care services that includes both a post-payment retrospective UR (performed after health care services are provided and paid), and a prepayment retrospective UR (performed after health care services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the ((~~department~~)) agency or its designee notifies the appropriate oversight entity if either of the following is identified:

(a) A quality of care concern; or

(b) Fraudulent conduct.

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

WAC 182-550-2521 Client eligibility requirements for acute PM&R services. (1) Only a client who is eligible for one of the ((~~following~~)) Washington apple health programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC ((~~388-550-2501, 388-550-2511, 388-550-2531, 388-550-2541, 388-550-2551, 388-550-2561, 388-550-3381~~)) 182-550-2501, 182-550-2511, 182-550-2531, 182-550-2541, 182-550-2551, 182-550-2561, 182-550-3381, and other rules:

(a) Categorically needy program (CNP);

(b) ((~~State~~)) Children's health insurance program (((~~SCHIP~~))) (CHIP);

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

(d) Alien emergency medical (AEM)(CNP);

(e) Alien emergency medical (AEM)(LCP-MNP);

(f) ((~~General assistance unemployable (GA-U - No out-of-state care); or~~

~~(g) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)~~)) Medical care services.

(2) If a client is enrolled in ((~~a department~~)) an agency managed care organization (MCO) plan at the time of acute care admission, that plan pays for and coordinates acute PM&R services as appropriate.

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

WAC 182-550-2650 Base community psychiatric hospitalization payment method for medicaid and ((~~SCHIP~~)) CHIP clients and nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients. (1) Effective for dates of admission from July 1, 2005 through June 30, 2007, and in accordance with legislative directive, the ((~~department~~)) agency implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and ((~~SCHIP~~)) children's health insurance program (CHIP) clients and one for nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and ((~~SCHIP~~)) CHIP clients and nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid or ((~~non-SCHIP~~)) non-CHIP client" is defined as a client eligible under the ((~~general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered~~)) medical care services (MCS) program, as determined by the ((~~department~~)) agency.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and ((~~SCHIP~~)) CHIP covered patients, paid to hospitals that accept commitments under the Involuntary Treatment Act (ITA).

(b) The nonmedicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070. In addition, the ((~~department~~)) agency considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The ((~~department~~)) agency does not consider detoxification to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate ((~~mental health division (MHD)~~)) division of behavioral health and recovery (DBHR) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC ((~~388-550-2600~~)) 182-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a ((~~MHD~~)) DBHR designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC ((~~388-550-2600~~)) 182-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act patient claim information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the county involuntary treatment office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and ((~~department-covered~~)) agency-covered services.

(6) The medicaid base community psychiatric hospitalization payment rate applies only to a medicaid or ((~~SCHIP~~)) CHIP client admitted to a nonstate-owned free-standing psychiatric hospital located in Washington state.

(7) The nonmedicaid base community psychiatric hospitalization payment rate applies only to a nonmedicaid or ((~~SCHIP~~)) CHIP client admitted to a hospital:

(a) Designated by the ((~~department~~)) agency as an ITA-certified hospital; or

(b) That has ((~~a department-certified~~)) an agency-certified ITA bed that was used to provide ITA services at the time of the nonmedicaid or ((~~non-SCHIP~~)) non-CHIP admission.

(8) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the ((~~department~~)) agency pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specific~~)) agency-specific nondiagnosis related group (DRG) payment method.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system.

(ii) For nonmedicaid and ((~~SCHIP~~)) CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A nonstate-owned free-standing psychiatric hospital as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and ((~~SCHIP~~)) CHIP clients, except the base community inpatient psychiatric hospital payment rate is the nonmedicaid rate, and the RCC allowable is the state-administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC ((~~388-550-4650~~)) 182-550-4650.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC ((~~388-550-4650~~)) 182-550-4650 in conjunction with the nonmedicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specified~~)) agency-specified non-DRG payment method.

(ii) For nonmedicaid ((~~[and] non-SCHIP~~)) and non-CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specified~~)) agency-specified non-DRG payment method.

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

WAC 182-550-6700 Hospital services provided out-of-state. (1) The ((~~department~~)) agency pays:

(a) For dates of admission before August 1, 2007, for only emergency care for an eligible medicaid and ((~~SCHIP~~)) CHIP client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC ((~~388-501-0175~~)) 182-501-0175 for a list of border cities.

(b) For dates of admission on and after August 1, 2007, for both emergency and nonemergency out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, for eligible medicaid and ((~~SCHIP~~)) CHIP clients based on the medical necessity and utilization review standards and limits established by the ((~~department~~)) agency.

(i) Prior authorization by the ((~~department~~)) agency is required for the nonemergency out-of-state hospital medical care provided to medicaid and ((~~SCHIP~~)) CHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As instate hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. ((~~Department~~)) Agency designated critical border hospitals are paid as instate hospitals. See WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible medicaid and ((~~SCHIP~~)) CHIP clients based on authorization by a ((~~mental health~~)) division of behavioral health designee.

(d) Based on the ((~~department's~~)) agency's limitations on hospital coverage under WAC ((~~388-550-1100 and 388-550-1200~~)) 182-550-1100 and 182-550-1200 and other applicable rules.

(2) The ((~~department~~)) agency authorizes and pays for comparable hospital services for a medicaid and ((~~SCHIP~~)) CHIP client who is temporarily outside the state to the same extent that such services are furnished to an eligible medicaid client in the state, subject to the exceptions and limitations in this section. See WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(3) The ((~~department~~)) agency limits out-of-state hospital coverage for ((~~clients~~)) persons eligible under state-administered programs as follows:

(a) For a ((~~client eligible under the psychiatric indigent inpatient (PII) program or~~)) person who receives services under the Involuntary Treatment Act (ITA), the ((~~department~~)) agency does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(b) For a ((~~client~~)) person eligible under ((~~a department's~~)) an agency's general assistance program, the ((~~department~~)) agency pays only for hospital services covered under the ((~~client's~~)) person's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The ((~~department~~)) agency does not pay for hospital services provided to ((~~clients~~)) persons eligible under a general assistance program in other hospitals located outside the state of Washington. The ((~~department~~)) agency or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC ((~~388-550-1200~~)) 182-550-1200.

(4) The ((~~department~~)) agency covers hospital care provided to medicaid or ((~~SCHIP~~)) CHIP clients in areas of Canada as described in WAC ((~~388-501-0180~~)) 182-501-0180, and based on the limitations described in the state plan.

(5) The ((~~department~~)) agency may review all cases involving out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, to determine whether the services are within the scope of the ((~~client's medical assistance~~)) person's WAH program.

(6) If the ((~~client~~)) person can claim deductible or coinsurance portions of medicare, the provider must submit the claim to the intermediary or carrier in the provider's own state on the appropriate medicare billing form. If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For payment for out-of-state inpatient hospital services, see WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(8) Out-of-state providers, including bordering city hospitals and critical border hospitals, must present final charges to the ((~~department~~)) agency within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment of charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-550-5125	Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

WSR 14-02-096
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed December 31, 2013, 9:38 a.m., effective January 1, 2014]

Effective Date of Rule: January 1, 2014.

Purpose: This emergency rule making supersedes the emergency rule making filed on September 30, 2013, as WSR 13-20-080. The department is amending rules in Title 388 WAC to remove medical references, support the creation of the housing and essential needs (HEN) referral program and remove references to the Alcohol and Drug Addiction Treatment and Support Act (ADATSA). 2E2SHB 1738, Laws of 2011, designated the health care authority (HCA) as the single state agency responsible for the administration and supervision of Washington's medical assistance programs. HCA recodified medical assistance program rules to Title 182 WAC. Accordingly, the department must eliminate corresponding rules and medical references under Title 388 WAC. New amendments have been made to WAC 388-406-0005, 388-406-0035, 388-406-0045, 388-406-0055, 388-418-0005, 388-424-0010 and 388-472-0005, that are currently in effect via emergency adoption (WSR 13-20-080). Amendments are made to support the creation of the new HEN referral program created under SHB 2069 and to remove references related to ADATSA. The legislature did not appropriate any funds for ADATSA in the new biennium budget. ADATSA-related medical care services recipients will be medicaid eligible under the Affordable Care Act starting January 1, 2014. Additional amendments spell out the acronym, ABD, identifying it as the aged, blind or disabled program. In addition, WAC 388-424-0015 is being amended to remove an ADATSA reference.

Citation of Existing Rules Affected by this Order: WAC 388-406-0005, 388-406-0035, 388-406-0045, 388-406-0055, 388-418-0005, 388-424-0010, 388-424-0015, 388-436-0030, 388-450-0015, 388-450-0025, 388-450-0040, 388-450-0156, 388-450-0162, 388-450-0170, 388-472-0005, and 388-473-0010.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.100, 74.04.770, 74.62.030, 41.05.021, 74.09.035, 74.09.530.

Other Authority: SHB 2069, Laws of 2013; 2E2SHB 1738, chapter 15, Laws of 2011; and the 2013 biennial budget.

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: Amendments remove medical references. More specifically, 2E2SHB 1738, Laws of 2011, designated HCA as the single state agency responsible for the administration and supervision of Washington's medical assistance programs. DSHS has been working with HCA to repeal medical assistance program rules under Title 388 WAC in support of HCA's efforts to recodify medical assistance program rules under Title 182 WAC. HCA recodified medical assistance program rules at Title 182 WAC, effective October 1, 2013. Accordingly, the department must eliminate corresponding rules under Title 388 WAC. Amendments remove references to the ADATSA program. The legislature did not appropriate any funds for ADATSA in the new biennium budget. ADATSA-related medical care services recipient[s] will be medicaid eligible under the Affordable Care Act starting January 1, 2014. Amendments support the creation of the new HEN referral program created under SHB 2069, which was signed by the governor on June 30, 2013.

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 16, 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 16, Repealed 0.

Date Adopted: December 19, 2013.

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 14-03 issue of the Register.

WSR 14-02-112
EMERGENCY RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed December 31, 2013, 4:00 p.m., effective December 31, 2013, 4:00 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: To correct the percentage of hours an individual must work to be eligible for participation in the shared work program. The percentages were misstated in the most recent filing.

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

Statutory Authority for Adoption: RCW 50.12.010 and 50.12.040.

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: The department is submitting a grant proposal to the United States Department of Labor requesting funding for Washington's shared work program. Inclusion of the rule with incorrect percentages may delay or preclude approval of the state's grant application.

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

Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

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

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 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 31, 2013.

Nan Thomas
Deputy Commissioner

AMENDATORY SECTION (Amending WSR 13-24-016, filed 11/21/13, effective 12/22/13)

WAC 192-250-035 Information for employees participating in an approved shared work plan. (1) **When do I apply for benefits?** Your employer representative will tell you if you need to apply for benefits and how to do so. If you have a current valid claim, you do not need to apply again.

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

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

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

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

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

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

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

(6) **Is there a minimum or maximum number of hours I can work in a week and still receive shared work benefits?** You must work between ((~~ten~~)) fifty percent and ((~~fifty~~)) ninety percent of your usual weekly hours to receive shared work benefits. In any week you work less than or more than that amount, your claim will be processed as a regular unemployment claim.

(7) **How long can I receive shared work benefits?** You can receive shared work payments up to the maximum benefit entitlement established under Title 50 RCW, plus state or federal benefit extensions under chapter 50.22 RCW.