WSR 14-03-026
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed January 8, 2014, 9:10 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-15-115.

Title of Rule and Other Identifying Information: The department is adding a new chapter 388-107 WAC that will provide licensing requirements for enhanced services facilities.

Hearing Location(s): Office Building 2, Auditorium, DSHS Headquarters, 1115 Washington Street S.E., Olympia, WA 98504 (public parking at 11th and Jefferson. A map is available at http://www11[www].dshs.wa.gov/msa/rpau/RPAU-OB-2directions.html or by calling (360) 664-6094), on March 11, 2014, at 10:00 a.m.

Date of Intended Adoption: Not earlier than March 12, 2014.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504-5850, 1115 Washington Street S.E., Olympia, WA 98504, e-mail DSHSRPAU RulesCoordinator@Qdshs[dshs].wa.gov, fax (360) 664-6185, by 5 p.m. on March 11, 2014.

Assistance for Persons with Disabilities: Contact Jennisha Johnson, DSHS rules consultant, by February 18, 2014, TTY (360) 664-6178 or (360) 664-6094 or by e-mail johnsjl4@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing these rules as a result of 3ESSB 5034. These rules will provide licensing requirements for enhanced services facilities. The legislature has directed that residents be placed in enhanced services facilities in 2014.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: Chapter 70.97 RCW, Enhanced services facilities.

Statute Being Implemented: Chapter 70.97 RCW, Enhanced services facilities.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of social and health services, governmental.

Name of Agency Personnel Responsible for Drafting: John Gaskell, P.O. Box 45600, Olympia, WA 98513, (360) 725-3210; Implementation: Irene Owens, P.O. Box 45600, Olympia, WA 98513, (360) 725-2489; and Enforcement: Lori Melchiori, P.O. Box 45600, Olympia, WA 98513, (360) 725-2404.

A small business economic impact statement has been prepared under chapter 19.85 RCW.

Small Business Economic Impact Statement

SUMMARY OF PROPOSED RULES: The department of social and health services' (DSHS) residential care services (RCS) is proposing regulations in the new chapter 388-107 WAC, Enhanced services facilities licensing requirements.

The purpose of this proposed rule making is to establish licensing requirements for enhanced services facilities, which is a new long-term care facility type established by chapter 70.97 RCW and funded by the 2013 legislature. RCS is proposing these new administrative rules because RCW 70.97.-230 directs the DSHS to adopt rules to implement chapter 70.97 RCW that, at a minimum, promote safe treatment and necessary care for residents who may reside at this newly-created facility type, to provide for safe and clean conditions, to establish licensee qualifications, to establish licensing and enforcement procedures, and to establish licensing fees.

The highlights of these new regulations include:

- Facilities must meet specific building physical plant requirements;
- Facilities may have up to sixteen residents;
- Facilities are required to report abuse and neglect;
- Residents have specific rights;
- Required trainings or credentials for staff providing direct care and services;
- Background checks for anyone having unsupervised access to residents;
- Residents will receive personal care and services, as well as mental health and/or behavioral health support;
- All residents will be state-pay (medicaid);
- Facilities will have a high staffing ratio, including the presence of (or access to) a registered nurse at all times.

The department has followed this stakeholder process to obtain input:

- Shared the draft language and draft small business economic statement and cost benefit analysis with interested parties who are on the enhanced services facilities interested party mailing list.
- In addition, the draft language and draft small business economic statement and cost benefit analysis will be posted on the aging and long-term support administration, enhanced services facilities internet web site for anyone in the public to review and comment.
- Department's process is to use the input from internal and external stakeholders to determine cost impacts for the drafting of the rule. To date, no comments have yet been received about costs for these proposed rules.

SMALL BUSINESS ECONOMIC IMPACT STATEMENT (SBEIS): Chapter 19.85 RCW, the Regulatory Fairness Act, requires that the economic impact of proposed regulations be analyzed in relation to small businesses. This statute outlines information that must be included in an SBEIS. Preparation of a SBEIS is required when a proposed rule has the potential of placing more than a minor impact on a business.

RCW 19.85.020 defines a "small business" as "any business entity, including a sole proprietorship, corporation, partnership, or other legal entity, that is owned and operated independently from all other businesses, and that has fifty or fewer employees."

RCS evaluated the impacts of this new WAC chapter. Since this is a brand new facility type that currently does not exist, there are no existing enhanced services facilities small businesses that will be impacted by these rules. Instead, the only small businesses that would be affected by these new rules are those who choose to be licensed as this new facility type. The costs will not have disproportionate economic impact on small businesses when compared to large businesses. It is believed that all enhanced services facilities will meet the definition of small business having fifty employees or less.

Each facility will need approximately six to seventeen staff each day, at a minimum. Specific staffing ratios will vary, depending on the needs of the residents. For example, a mental health professional is a required to be on staff at the facility for sixteen hours per day, a licensed nurse must be in the facility at all times, and a registered nurse must be on site for at least eight hours per day and on call at all other times. A facility would require additional staff to ensure all shifts are adequately staffed throughout the week in order to comply with these rules. Depending on the facility's staffing plans, six - thirty-four new jobs could be created at each facility (six jobs would require each staff to work every day for seven days and would incur extremely high overtime costs; thirty-four jobs would allow for seventeen staff for weekdays and seventeen staff for weekends). Facilities may need to hire beyond these staffing estimates in order to ensure the services required in the contract are provided to the residents. Since this is a new facility type, no jobs are anticipated to be lost.

RCS has looked at ways to mitigate costs to small businesses that may decide to be licensed as an enhanced services facility. Here are some examples:

- The statute allows for existing adult family homes, nursing homes, and assisted living facilities who convert to enhanced services facilities to be deemed to meet the applicable state and local rules, regulations, permits, and code requirements. This helps mitigate disproportionate costs to these small businesses since they will not need to renovate or remodel to meet the physical plant requirements unless it is a risk to resident health and safety.
- The department used staffing ratio requirements to help determine the rate the providers will receive.
- The enhanced services facilities statute requires that the department set a license fee to cover the oversight costs. The department is looking at offering payment options to mitigate an upfront large fee payment due.

EVALUATION OF PROBABLE COSTS AND PROBABLE BENEFITS: RCS has determined that some of the proposed rules are "significant legislative rules" as defined by legislature. As required by RCW 34.05.328 (1)(c) and (d), RCS has analyzed the probable costs and probable benefits of the proposed amendments, taking into account both the qualitative and quantitative benefits and costs and the specific directives of the statute being implemented. In RCW 70.97.230, the legislature mandated DSHS to adopt rules to implement chapter 70.97 RCW, including at a minimum to adopt rules sufficient to promote safe treatment and necessary care of individuals residing in this new facility type, to provide for safe and clean conditions, to establish licensee qualifications, to establish licensing and enforcement procedures, and to establish licensing fees sufficient to cover the cost of licensing and enforcement. This new WAC chapter is created to fulfill the specific directive of the statute being implemented.

COSTS: There are currently no small businesses that operate this facility type. RCS is mandated by the legislature in RCW 70.97.230 to establish licensing requirements for this brand new facility type.

It is the intent of the department that all residents served in enhanced services facilities will be department clients and services paid through a medicaid waiver. Each enhanced services facilities will need to contract with the department (home and community services) to receive payment and will need to adhere to contract requirements. The following are examples of contract requirements that may cost but were put into licensing regulations to be consistent:

- Approximately six to thirty-four jobs would be created to provide direct care and services to the residents of the enhanced services facility; additional staff that do not provide direct care and services may be needed.
- The liability insurance requirement for enhanced services facilities may impose additional costs.
- Background check requirements for staff with unsupervised access are required, but this is paid by the department so that the facility will not incur any costs for this requirement.
- Specialty training requirements such as mental health and dementia for staff with unsupervised access and long-term care worker training requirements.
- If a resident needs chemical dependency treatment, the facility must contract with a chemical dependency agency or provider for this service.
- The contract requires the facility to have an administrator, which may be an additional staff person, unless the administrator will also provide direct care and services to residents.

Other examples of cost enhanced services facilities may incur are:

- Licensing fee; however, the department is looking at offering payment options to mitigate an upfront large fee payment due.
- Newly constructed enhanced services facilities will need to meet applicable state and local rules, regulations, permits, and code requirements. There may be building, renovation, and physical plant improvements needed for existing facilities to ensure the health and safety of residents.
- Adult family homes and assisted living facilities converting to an enhanced services facility will likely incur costs related to specific physical plant requirements, such as a significant backup power system.
- Cost of administering each staff person tuberculosis test within three days of employment.

BENEFITS: The rules result in several benefits which include:

- Residents will be in a less-restrictive environment and will receive recommended services including mental health and chemical dependency services, along with having their care needs met.
- Residents will reside in a homelike community setting.
- Residents will be served by staff that passed background checks and are trained specifically in specialty areas to meet their needs.
- Placing residents in enhanced services facilities will potentially open up beds in the state hospitals for individuals who are in the need of active mental health treatment.
- Jobs will be created to work at this new licensed facility category.
- The liability insurance, license fee, background checks, training, tuberculosis testing and administrator requirements will provide a consistent standard among all licensed long-term care settings in Washington.
- The liability insurance requirement will provide all residents with another level of consumer protection. It can also help enhanced services facilities defend themselves and pay awarded damages without threatening their financial stability.
- The tuberculosis testing requirement will ensure that residents in enhanced services facilities are not at higher risk for contacting infectious diseases.
- Requiring an administrator protects residents since this staff must be readily accessible to meet with residents and is ultimately responsible for ensuring residents receive the care and services identified in their individual treatment plan and assessment.

CONCLUSION: RCS concludes that the benefits of these regulations exceed any possible cost. These rules will implement state laws and carry out legislative directive to create this new license category. RCS has complied with the appropriate sections of the Administrative Procedure Act and is prepared to proceed with the rule filing.

Please contact John Gaskell by e-mail gaskejw@dshs.wa.gov or phone (360) 725-3210 if you have questions.

A copy of the statement may be obtained by contacting John Gaskell, P.O. Box 45600, Olympia, WA 98513, phone (360) 725-3210, fax (360) 438-7903, e-mail gaskejw@dshs.wa.gov.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting John Gaskell, P.O. Box 45600, Olympia, WA 98513, phone (360) 725-3210, fax (360) 438-7903, e-mail gaskejw@dshs.wa.gov.

January 2, 2014
Katherine I. Vasquez
Rules Coordinator

Definitions

NEW SECTION

WAC 388-107-0001 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

"Advance directive," as used in this chapter, means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney health care directive, limited or restricted treatment cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), and organ tissue donation.

"Aggressive behavior" means actions by the individual that constitute a threat to the individual's health and safety or the health and safety of others in the environment.

"Antipsychotic medications" means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes but is not limited to atypical antipsychotic medications.

"Capacity" means the maximum amount an enhanced services facility can serve is sixteen residents.

"Caregiver" means the same as "Long-Term Care Worker" as defined in RCW 74.39A.009, as follows: "Long-term care workers" include all persons who provide paid, hands-on personal care services for the elderly or persons with disabilities, including but not limited to individual providers of home care services, direct care workers employed by home care agencies, providers of home care agencies to persons with developmental disabilities under title 71A RCW, all direct care workers in state-licensed assisted living facilities, and adult family homes, respite care providers, direct care workers employed by community residential service businesses, and any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

"Challenging behavior" means a persistent pattern of behaviors that inhibit the individual's functioning in public places, in the facility and integration within the community, or uncontrolled symptoms of a physical or mental condition. These behaviors may have been present for long periods of time or have manifested as an acute onset.

"Chemical dependency" means alcoholism, drug addiction, or dependence on alcohol and one or more other psychoactive chemicals, as the context requires and as those terms are defined in chapter 70.96A RCW.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the department of health under chapter 18.205 RCW.

"Department" means the department of social and health services.

"Enhanced services facility" means a facility that provides treatment and services to persons for whom acute inpatient treatment is not medically necessary and who have been determined by the department to be inappropriate for placement in other licensed facilities due to the complex needs that result in behavioral and security issues. For the purposes of this chapter, an enhanced services facility is not an evaluation and treatment facility certified under chapter 71.05 RCW.

"Facility" means an enhanced services facility.

"Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

"Likelihood of serious harm" means a substantial risk that:

(1) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;

(2) Physical harm will be inflicted by an individual upon another, as evidenced by behavior that has caused such harm or that places another person or persons in reasonable fear of sustaining such harm; or

(3) Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior that has caused substantial loss or damage to the property of others.

"Medically fragile" means a chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled nursing interventions. If these medically-necessary interventions are interrupted or denied, the resident may experience irreversible damage or death. Examples of specialized medical care and treatment for medically fragile residents include but are not limited to: IV therapies requiring monitoring of vital signs and dose titration dependent on lab values; wound care requiring external vacuum or other mechanical devices for debridement; complicated wound care requiring other specialized or extensive interventions and treatment; ventilator or other respiratory device dependence and monitoring; dependence on licensed staff for complex respiratory support; and peritoneal or hemodialysis (on-site).

"Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

"Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, licensed mental health counselor, licensed mental health counselor-associate, licensed marriage and family therapist, licensed marriage and family therapist-associate, licensed independent clinical social worker, licensed independent clinical social worker-associate, licensed advanced social worker, or licensed advanced social worker-associate and such other mental health professionals as may be defined by rules adopted by the secretary under the authority of chapter 71.05 RCW.

"Permanent Restraining Order" means a restraining order or order of protection issued either following a hearing, or by stipulation of the parties. A "permanent" order may be in force for a specific time period (e.g. 5 years), after which it expires.

"Physical intervention" means the use of a manual technique intended to interrupt or stop a behavior from occurring. Physical intervention includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

"Physical restraint" means **manually** holding all or part of a person's body in a way that restricts the person's free movement; also includes any approved controlling maneuvers, such as holds taught in approved training for de-escalation techniques and control of self-harm or aggressive behavior. **This definition does not apply to briefly holding, without undue force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.**

"Professional person" means a mental health professional and also means a physician, registered nurse, and such others as may be defined in rules adopted by the secretary pursuant to the provisions of this chapter.

"Psychiatrist" means a person having a license as a physician and surgeon in this state who has in addition completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association and is certified or eligible to be certified by the American board of psychiatry and neurology.

"Psychologist" means a person who has been licensed as a psychologist under chapter 18.83 RCW.

"Registration records" include all the records of the department, regional support networks, treatment facilities, and other persons providing services to the department, county departments, or facilities which identify individuals who are receiving or who at any time have received services for mental illness.

"Resident" means a person admitted to an enhanced services facility.

"Secretary" means the secretary of the department or the secretary's designee.

"Significant change" means:

(1) A deterioration in a resident's physical, mental, or psychosocial condition that has caused or is likely to cause clinical complications or life-threatening conditions; or

(2) An improvement in the resident's physical, mental, or psychosocial condition that may make the resident eligible for discharge or for treatment in a less intensive or less secure setting.

"Significant medication error" includes any failure to administer or receive a medication according to an authorized health care provider's order, or according to the manufacturer's directions for nonprescription drugs, that results in an error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration.

"Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.-010.

"Staff" means any person who is employed by the enhanced services facility, directly or by contract.

"Temporary Restraining Order" means restraining order or order of protection that expired without a hearing, was terminated following an initial hearing, or was terminated by stipulation of the parties in lieu of an initial hearing.

"Treatment" means the broad range of emergency, detoxification, residential, inpatient, and outpatient services and care, including diagnostic evaluation, mental health or chemical dependency education and counseling, medical, physical therapy, restorative nursing, psychiatric, psychological, and social service care, vocational rehabilitation, and career counseling.

General

NEW SECTION

WAC 388-107-0010 Scope and purpose. This implements Chapter 70.97 RCW and sets the minimum health and safety standards for licensure and operations of enhanced services facilities. An enhanced services facility will provide treatment and services to a maximum of sixteen residents for whom acute inpatient treatment is not medically necessary and who have been determined by the department to be inappropriate for placement in other licensed facilities due to the complex needs that result in behavioral and security issues.

NEW SECTION

WAC 388-107-0020 Department authority. Chapter 70.97 RCW authorizes the department to develop rules to implement the chapter, and to license enhanced services facilities. At a minimum the rules are to be written to promote safe treatment and necessary care of individuals residing in each facility, to provide for safe and clean conditions and to establish licensee qualifications, licensing and enforcement standards, and license fees sufficient to cover the cost of licensing and enforcement.

Admission and Assessment

NEW SECTION

WAC 388-107-0030 Admission criteria. The enhanced services facility will only admit residents who:

(1) Are at least eighteen years old; and

(2) Require:

(a) Daily care by or under the supervision of a mental health professional, chemical dependency professional, or nurse; or

(b) Assistance with three or more activities of daily living; and

(3) Have any of the following:

(a) A mental disorder, chemical dependency disorder, or both;

(b) An organic or traumatic brain injury; or

(c) A cognitive impairment that results in symptoms or behaviors requiring supervision and facility services; and

(4) Have two or more of the following:

(a) Self-endangering behaviors that are frequent or difficult to manage;

(b) Aggressive, threatening, or assaultive behaviors that create a risk to the health or safety of other residents or staff, or a significant risk to property and these behaviors are frequent or difficult to manage;

(c) Intrusive behaviors that put residents or staff at risk;

(d) Complex medication needs which include psychotropic medications;

(e) A history of or likelihood of unsuccessful placements in either a licensed facility or other state facility or a history of rejected applications for admission to other licensed facilities based on the resident's behaviors, history, or security needs;

(f) A history of frequent or protracted mental health hospitalizations; and/or

(g) A history of offenses against a person or felony offenses that created substantial damage to property.

NEW SECTION

WAC 388-107-0040 Preadmission assessment. (1) The enhanced services facility must complete a face to face preadmission assessment with each potential resident prior to admission which includes the following minimum information:

(a) Resident identification information such as but not limited to the name, address and telephone number of the resident's:

(i) Representative;

(ii) Health Care providers;

(iii) Significant family members identified by the resident; and

(iv) Other individuals the resident wants involved or notified.

(b) Presenting issues;

(c) Current medical and mental health history;

(d) Necessary and contraindicated medications, including psychotropic;

(e) A licensed medical or health professional's physical and mental health diagnoses;

(f) Significant known behaviors such as but not limited to aggressive, threatening, intrusive, assaultive, self-endangering including suicide and/or homicide or other symptoms that may cause concern or require special care and staffing;

(g) Chemical dependency history, including tobacco;

(h) Level of personal care needs, assistance with activities of daily living;

(i) Activities and service preferences;

(j) Preferences regarding other issues important to the prospective resident, such as food and daily routine;

(k) Information that a resident is or is not court-ordered for treatment or under the supervision of the department of corrections;

(l) Cognitive impairments that result in symptoms of behaviors requiring supervision and facility services;

(m) History of unsuccessful placement in the community settings; and

(n) Treatment recommendations or recommendations for additional program-specific assessment.

(2) The enhanced services facility will integrate information from the state's last comprehensive assessment reporting evaluation (CARE) into the facility's preadmission assessment.

NEW SECTION

WAC 388-107-0050 Timing of preadmission assessment. The assessor must complete the preadmission assessment of the prospective resident before the resident moves into the enhanced services facility.

NEW SECTION

WAC 388-107-0060 Comprehensive assessment required. (1) The enhanced services facility must complete a comprehensive assessment for each resident within fourteen (14) days of admission.

(2) The assessment will be repeated when there is a significant change in the resident's condition or, at a minimum, every one hundred eighty days if there is no significant change in condition.

NEW SECTION

WAC 388-107-0070 Comprehensive assessment. The enhanced services facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a comprehensive assessment**,** that includes the elements of the CARE assessment, and addresses the following, within fourteen days of the resident's move-in date:

(1) Individual's recent medical history, including, but not limited to:

(a) Diagnoses from a licensed medical or health professional, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including any prescribed medications, over-the-counter medications, and antipsychotic drugs.

(3) The individual's nursing needs.

(4) Significant known challenging behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property;

(c) Other conditions that require behavioral intervention strategies;

(d) Individual's ability to leave the enhanced services facility unsupervised;

(e) Any court order or court stipulation regarding activities, surroundings, behaviors, and treatments; and

(f) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted outdoors in a specific location on the premises.

(5) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool to determine the presence of symptoms consistent with, and implications for, care and services of:

(a) Mental illness, or needs for psychological or mental health services;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the enhanced services facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury or other neurological conditions.

(6) Individual's activities, typical daily routines, habits and service preferences.

(7) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(8) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker or court orders for treatment, or documents indicating resident is under the supervision and care of the department of corrections; and

(c) The scope of decision-making authority of any substitute decision maker.

(9) A plan to use antipsychotic drugs as diagnosed and documented in the clinical record in accordance with chapters 71.05 and 70.97 RCW.

NEW SECTION

WAC 388-107-0080 On-going comprehensive assessments. The enhanced services facility must:

(1) Complete a comprehensive assessment, addressing the elements set forth in WAC 388-107-0070, upon a significant change in the resident's condition or at least every 180 days if there is no significant change in condition;

(2) Complete an assessment specifically focused on a resident's identified strengths, preferences, limitations and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-107-0060;

(b) When the resident's individual treatment plan no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

(3) Ensure the staff person performing the on-going assessments is qualified to perform them.

NEW SECTION

WAC 388-107-0090 Qualified assessor. (1) The enhanced services facility must ensure that an assessor performing an assessment for any potential or admitted resident has experience working with residents who have severe behavioral issues due to but not limited to functional or cognitive disabilities, mental health or chemical dependency disorder, or both, or an organic or traumatic brain injury and meets the following qualifications:

(a) A master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have severe behavioral issues; or

(b) A bachelor's degree in social services, human services, behavioral sciences or an allied field and five years

social service experience working with adults who have severe behavioral issues; or

(c) Has a valid Washington state license to practice as a nurse under chapter 18.79 RCW and three years of clinical nursing experience working with adults who have severe behavioral issues; or

(d) Is currently a licensed physician, including an osteopathic physician, in Washington state with experience working with adults who have severe behavioral issues; or

(e) Is a licensed psychologist or psychiatrist; or

(f) Is a professional appropriately credentialed or qualified to provide chemical dependency, mental health, organic or traumatic brain injury and/or functional or cognitive services and work experience with adults who have severe behavioral issues.

(2) The facility must ensure that an assessor who meets the requirements of subsections (1)(a), (b), (c), (d), (e), or (f) of this section does not have unsupervised access to any resident unless the assessor has:

(a) A current criminal history background check; and

(b) Has no disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

Individual Treatment Plan

NEW SECTION

WAC 388-107-0100 Enhanced services facility team. The facility will identify a team for each resident. The team will:

(1) Include the resident and any support persons identified by the resident, as well as a mental health professional, nursing staff, and other persons identified by the facility;

(2) Ensure a coordinated approach to the development, implementation and evaluation of the individual treatment plan for the resident; and

(3) Meet at least monthly to review and modify the individual treatment plan as needed.

NEW SECTION

WAC 388-107-0110 Initial individual treatment plan. The enhanced services facility team must develop the initial individual treatment plan, using information from the resident, the resident's representative if the resident has one, the Comprehensive Assessment Reporting Evaluation (CARE) assessment, and the preadmission assessment, prior to admitting the resident to the facility. The enhanced services facility team must ensure that each resident has an initial individual treatment plan that includes:

(1) The resident's immediate specific problems and needs (physical, mental and behavioral) identified in the CARE assessment and the pre-assessment;

(2) Direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences;

(3) The needs for which the resident chooses not to accept or refuses care or services;

(4) What the facility will do to ensure the resident's health and safety related to the refusal of any care or service;

(5) Resident defined goals and preferences;

(6) How the facility will provide behavioral support to prevent a crisis and maintain placement in the facility; and

(7) Identifying factors that will prevent the resident from accessing less restrictive community based services and developing a plan regarding when and how the resident may be able to transfer or transition from the enhanced services facility to a more independent living situation in the community.

NEW SECTION

WAC 388-107-0120 Comprehensive individual treatment plan. The enhanced services facility team must integrate the information obtained in the resident's preadmission assessment, CARE assessment information from the department's case manager, comprehensive assessment and initial individual treatment plan to develop a written comprehensive individual treatment plan. The enhanced services facility team must ensure each resident's comprehensive individual treatment plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

(4) How medications will be managed, including how the resident will get medications when the resident is not in the facility;

(5) The resident's daily activities preferences, interests, strengths and needs and how the facility will meet those within the behavioral challenges of the resident;

(6) Other preferences and choices about issues important to the resident, including, but not limited to:

(a) Food;

(b) Daily routine;

(c) Grooming; and

(d) How the enhanced services facility will accommodate the preferences and choices.

(7) A behavioral support plan to prevent crisis and maintain placement in the facility by:

(a) A crisis prevention and response protocol that outlines specific indicators which may signal a potential crisis for the resident;

(b) Specific interventions and pre-crisis prevention strategies for each of the resident's indicators of a potential crisis;

(c) A crisis prevention and response protocol that outlines steps to be taken if the prevention or intervention strategies are unsuccessful in diverting the crisis including the community crisis responder's coordination plan; and

(d) A plan on how to respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal.

(8) Identification of any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident;

(9) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

(10) Advance directives, if the resident chooses, that are validly executed pursuant to chapters 70.122 RCW and 71.32 RCW, as applicable;

(11) A plan regarding how the facility will work with the Department of Corrections (DOC) if the resident is under the supervision of DOC, collaborating to maximize treatment outcomes and reduce the likelihood of re-offense.

(12) A plan which maximizes the opportunities for independence, maintaining health and safety, recovery, employment, the resident's participation in treatment decisions, collaboration with peer-supported services and care and treatment provided in the least restrictive manner appropriate to the resident and to any relevant court orders with which the resident must comply.

(13) A discharge plan that addresses factors and barriers that prevent a resident from being placed in a less restrictive community placement and assist the resident in the transition. This plan will include an assessment of all current medications and the resident's ability to self-medicate in a more independent living situation.

(14) The enhanced services facility must complete the comprehensive individual treatment plan within fourteen days of the resident's move-in date.

NEW SECTION

WAC 388-107-0130 On-going comprehensive individual treatment plan. (1) The enhanced services facility team will review and update each resident's comprehensive individual treatment plan, as follows:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, emotional or behavioral functioning; and

(b) Whenever the comprehensive individual treatment plan no longer adequately addresses the resident's current assessed needs and preferences; and

(c) Following every full comprehensive assessment.

(2) The process of developing and updating the comprehensive individual treatment plan will include the following:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(d) The department's case manager; and

(e) Staff designated by the enhanced services facility.

(3) The enhanced services facility team will ensure:

(a) Individuals participating in developing the resident's comprehensive individual treatment plan:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate, if possible and feasible, an agreed upon comprehensive individual treatment plan which would support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

NEW SECTION

WAC 388-107-0140 Implementation of the individual treatment plan. (1) The enhanced services facility must provide the care and services as agreed upon or outlined in the initial and comprehensive individualized treatment plan to each resident unless a deviation from the plan is mutually agreed upon between the enhanced services facility team, the department's case manager, and the resident or the resident's representative at the time the care or services are scheduled.

(2) The details of any deviation from the plan must be clearly documented in the resident record.

NEW SECTION

WAC 388-107-0150 Comprehensive individual treatment plan sent to the state. Because each resident's services are paid for by the department, the enhanced services facility must give the department case manager a copy of the comprehensive individual treatment plan each time it is completed or updated and after it has been signed and dated. The department's case manager will:

(1) Review the individual treatment plan;

(2) Sign, date, and return the individual treatment plan to the facility;

(3) Document the review in the resident record, indicating it was signed and approved; and

(4) Schedule a department reassessment.

NEW SECTION

WAC 388-107-0160 Behavioral support plan. The enhanced services facility will ensure that each resident's individual treatment plan has interventions for behavioral support that are used first when a resident's behavior is escalating, including but not limited to the following:

(1) Specific indicators which may signal a potential crisis for the individual or that left unaddressed in the past has led to a behavioral crisis. Examples include but are not limited to typical challenging behaviors the individual displays when escalating, actions the resident may typically take before a behavioral outburst, or words or phrases the individual has been known to express during a time of escalation.

(2) Specific interventions and pre-crisis prevention strategies for each of the indicators identified above.

(3) Steps to be taken by each of the facility team members if the prevention or intervention strategies are unsuccessful in diverting the individual from a behavior or action that leads to crisis.

(4) A plan to ensure coordination with community crisis responders in regard to each resident's treatment plan as part of a regular, routine protocol for crisis prevention and intervention.

(5) A resident may not be secluded or isolated as part of the behavior support plan.

Resident Rights

NEW SECTION

WAC 388-107-0170 Resident dignity and accommodation of needs. (1) The enhanced services facility must ensure that:

(a) Resident care is provided in a manner to enhance each resident's dignity and quality of life including a safe,

clean, comfortable and homelike environment, and to respect and recognize his or her individuality; and

(b) Each resident's personal care needs and behavioral health treatment are provided in a manner that protects resident's dignity and privacy.

(2) Each resident has the right to reasonable accommodation of personal needs and preferences, except when the health or safety of the individual or other residents would be endangered.

NEW SECTION

WAC 388-107-0180 Self-determination and participation. Except when the health or safety of the individual or other residents would be endangered and consistent with the individual treatment plan, each resident has the right to:

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and individual treatment plan;

(2) Interact with members of the community both inside and outside the enhanced services facility;

(3) Make choices about aspects of his or her life in the facility that are significant to the resident; and

(4) Participate in social, religious, and community activities that do not interfere with the rights of other residents in the enhanced services facility.

NEW SECTION

WAC 388-107-0190 Rights of residents. (1)(a) Each resident of an enhanced services facility is entitled to all the rights set forth in this chapter, and chapters 71.05 and 70.96A RCW, and must retain all rights not denied him or her under these chapters.

(b) The enhanced services facility will only consider a resident's competence as determined or withdrawn under the provisions of chapters 10.77 or 11.88 RCW.

(c) The facility must give each resident, at the time of his or her treatment planning meeting, a written statement setting forth the substance of this section.

(2) Every resident of an enhanced services facility has the right to adequate care and individualized treatment.

(3) The provisions of this chapter must not be construed to deny to any resident treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.

(4) Each resident of an enhanced services facility must have, in addition to other rights not specifically withheld by law, the rights enumerated in (a) through (l) below, unless exercise of these rights creates a danger to the resident or to others. The facility must prominently post a list of these rights in a place accessible to residents and must make this list available to residents without need of request. The resident has the right:

(a) To wear his or her own clothes and to keep and use his or her own personal possessions, except when deprivation of same is essential to protect the safety of the resident or other persons;

(b) To have access to fluids and snacks of choice;

(c) To keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases;

(d) To have access to individual storage space for his or her private use;

(e) To have visitors at reasonable times;

(f) To have reasonable access to a telephone, both to make and receive confidential calls, consistent with an effective treatment program;

(g) To have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mails;

(h) To discuss and actively participate in treatment plans and decisions with professional persons;

(i) To a clean, comfortable and home-like environment;

(j) Not to have psychosurgery performed on him or her under any circumstances;

(k) To dispose of property and sign contracts unless the resident has been adjudicated an incompetent in a court proceeding directed to that particular issue; and

(l) To complain about rights violations or conditions and request the assistance of a mental health ombuds or representative of Washington protection and advocacy. The facility may not prohibit or interfere with a resident's decision to consult with an advocate of his or her choice.

(5) Nothing contained in this chapter must prohibit a resident from petitioning by writ of habeas corpus for release.

(6) Nothing in this section permits any person to knowingly violate a no-contact order or a condition of an active judgment and sentence or active supervision by the department of corrections.

(7) A resident has a right to refuse placement in an enhanced services facility. No person must be denied other department services solely on the grounds that he or she has made such a refusal.

(8) A resident has a right to appeal the decision of the department that he or she is eligible for placement at an enhanced services facility, and must be given notice of the right to appeal in a format that is accessible to the resident with instructions regarding what to do if the resident wants to appeal.

Quality of Care

NEW SECTION

WAC 388-107-0200 Quality of care. (1) Consistent with resident rights, the enhanced services facility must provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, self-care and independence in accordance with his or her comprehensive assessment and individual treatment plan.

(2) Based on the comprehensive assessment of a resident, the enhanced services facility must ensure that:

(a) A resident's abilities in activities of daily living do not decline unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable. This includes the resident's ability to:

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and
(v) Use speech, language, or other functional communication systems.

(b) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities in activities of daily living specified in subsection (2)(a) of this section; and

(c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(3) The enhanced services facility must ensure that the appropriate care and services are provided to the resident in a minimum of the following areas, as applicable in accordance with the resident's individualized assessments and individual treatment plan:
(a) Mental health treatment;
(b) Chemical dependency treatment;
(c) Vision and hearing;
(d) Skin;
(e) Continence;
(f) Range of motion;
(g) Mental and psychosocial functioning and adjustment;
(h) Nutrition;
(i) Hydration;
(j) Special needs, including but not limited to:
(i) Injections;
(ii) Parenteral and enteral fluids;
(iii) Colostomy, ureterostomy, or ileostomy care;
(iv) Tracheostomy care and/or tracheal suctioning;
(v) Respiratory care;
(vi) Dental care;
(vii) Foot care; and
(viii) Prostheses.
(k) Medications, including freedom from:
(i) Unnecessary drugs; and
(ii) Significant medication errors; and
(l) Independent living skills.

NEW SECTION

WAC 388-107-0210 Care and services. The enhanced services facility must develop and implement a program to meet the needs of each resident and to ensure each resident receives:

(1) The care and services identified in the individualized treatment plan.

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

(4) Services by the appropriate professionals based upon the resident's assessment and individualized treatment plan.

Quality Improvement

NEW SECTION

WAC 388-107-0220 Quality improvement. (1) To ensure the proper delivery of services and the maintenance and improvement in quality of care through self-review, any enhanced services facility licensed under this chapter must maintain a quality improvement committee.

(2) The quality improvement committee will include a multi-disciplinary team.

(3) The quality improvement committee will plan one continuous quality improvement project annually, beginning in the second contract year for completion by the end of the second calendar year.

Nursing Services and Staffing

NEW SECTION

WAC 388-107-0230 Sufficient staffing. An enhanced services facility must have sufficient numbers of staff with the appropriate credentials and training to provide residents with the identified care and treatment needs. At a minimum the facility must have staff to provide:

(1) Mental health and/or chemical dependency treatment;

(2) Medication management services;

(3) Personal care, assistance with the activities of daily living;

(4) Medical treatment, including psychiatric;

(5) Activities;

(6) Social service support;

(7) Negotiated services;

(8) Dietary services; and

(9) Security.

NEW SECTION

WAC 388-107-0240 Staffing ratios. (1) The enhanced services facility must ensure that:

(a) Sufficient numbers of appropriately qualified and trained staff are available to provide necessary care and services consistent with residents' negotiated service agreements safely under routine conditions, as well as during fire, emergency, and disaster situations; and

(b) At least two staff are on duty in the facility at all times if there are any residents in the facility.

(2) A licensed nurse must be on duty in the facility at all times.

(a) A registered nurse must be on duty at least eight hours per day; and

(b) A registered nurse must be on call during any shift that a licensed practical nurse is on duty.

(3) A mental health professional must be on-site at least six-teen hours per day.

NEW SECTION

WAC 388-107-0250 Staffing credentials and qualifications. (1) The enhanced services facility must ensure the staffing ratios are met with the following credentialed staff, who are in good professional standing:

(a) Registered nurse;

(b) Licensed practical nurse;

(c) Nursing Assistant Certified or Certified Home Care Aide; and

(d) Mental health professional.

(2) The enhanced services facility must ensure that any caregiver, excluding professional licensed nursing staff:

(a) Must be at least 18 years of age;

(b) Has successfully completed a department-approved certified nursing assistant training program; or

(c) Meets the long-term worker training and certification requirements of Chapter 388-112 WAC.

NEW SECTION

WAC 388-107-0260 Staffing for medically fragile residents. If an enhanced services facility serves one or more medically fragile residents, the facility must ensure that a registered nurse is on site for at least sixteen hours per day. A registered nurse or a doctor must be on-call during the remaining eight hours.

NEW SECTION

WAC 388-107-0270 Providing care and services. The enhanced services facility must ensure that all staff, including management, provide care and services consistent with:

(1) Empowering each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, self-care and independence;

(2) Respecting resident rights; and

(3) Enhancing each resident's quality of life.

Operations

NEW SECTION

WAC 388-107-0280 Transfer and discharge. (1) Upon completion of the annual reassessment and/or significant change assessment by both case management and enhanced services facility staff, the enhanced services team will review each resident for possible discharge. The team will determine if the resident:

(a) No longer needs the level of behavioral support provided by the enhanced services facility;

(b) Behaviors are now mitigated by changed medical or personal care needs;

(c) Expresses the desire to move to a different type of community based setting and has demonstrated the ability or capacity to be successful; or

(d) Is a good candidate for relocation and recommends other community based programs to the resident.

(2) The enhanced services facility, with input from the team, will meet with case management staff to identify residents with potential for discharge or transfer to a less restrictive program, and will participate in discharge planning for each resident who meets the above criteria for potential discharge from the facility.

(3) The enhanced services facility must provide a thirty (30) day notice before discharging a resident unless the situation is emergent and the case manager is involved in the decision.

Services Provided

NEW SECTION

WAC 388-107-0290 Activities. The enhanced services facility must:

(1) Provide space and staff support necessary for:

(a) Each resident, at any time, to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, choices, functional abilities, preferences, and individualized treatment plan; and

(b) Group activities at least five times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

(2) Make available routine supplies and equipment necessary for activities described in subsection (1) of this section.

NEW SECTION

WAC 388-107-0300 Admission and continuation of services. The enhanced services facility must only admit or continue to provide services to a resident when:

(1) The department has determined that the individual is eligible for placement in an enhanced services facility.

(2) The facility can safely and appropriately meet the assessed needs and preferences of the resident:

(a) With available staff; and

(b) Through reasonable accommodation.

(3) Admitting the resident does not negatively affect the ability of the facility to:

(a) Meet the needs, and does not endanger the safety, of other residents; or

(b) Safely evacuate all people in the facility during an emergency according to the approved fire safety and evacuation plans appropriate to the occupancy type of the building.

NEW SECTION

WAC 388-107-0310 Medical and/or adaptive equipment. The enhanced services facility is responsible to meet the needs of residents through qualified and trained staff, services, medical and/or adaptive equipment and building design.

NEW SECTION

WAC 388-107-0320 Medication services. (1) An enhanced services facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW regarding legend and prescription drugs, and other applicable statutes and administrative rules;

(b) Develop and implement systems that support and promote safe medication service for each resident; and

(c) Ensure that each resident is monitored for desired responses and undesirable side effects of prescribed drugs.

(2) The enhanced services facility must ensure residents receive their medications as prescribed.

NEW SECTION

WAC 388-107-0330 Pharmacy services. (1) The enhanced services facility must:

(a) Obtain routine and emergency drugs and biologicals for its residents under an agreement with a licensed pharmacy;

(b) Ensure that pharmaceutical services:

(i) Meet the needs of each resident;

(ii) Establish and monitor systems for the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals; and

(c) Employ or obtain the services of a license pharmacist who must:

(i) Provide consultation on all aspects of the provision of pharmacy services in the enhanced services facility;

(ii) Determine that enhanced services facility drug records are in order;

(iii) Perform regular reviews at least once each month of each resident's drug therapy; and

(iv) Document and report drug irregularities to the attending physician.

(2) Drugs and biologicals used in the enhanced services facility must be labeled and stored in accordance with applicable state and federal laws.

(3) The enhanced services facility must provide pharmaceutical services that meet recognized and accepted standards of pharmacy practice.

(4) The enhanced services facility must ensure:

(a) Education and training for enhanced services facility staff by the licensed pharmacist on drug-related subjects including, but not limited to:

(i) Recognized and accepted standards of pharmacy practice and applicable pharmacy laws and rules;

(ii) Appropriate monitoring of residents to determine desired effect and undesirable side effects of drug regimens; and

(iii) Use of psychotropic drugs.

(b) Reference materials regarding medication administration, adverse reactions, toxicology, and poison center information are readily available;

(c) Pharmacist monthly drug review reports are acted on in a timely and effective manner;

(d) Accurate detection, documentation, reporting and resolution of drug errors and adverse drug reactions; and

(e) Only individuals authorized by state law to do so will receive drug orders and administer drugs.

(5) The resident has the right to a choice of pharmacies when purchasing prescription and nonprescription drugs as long as the following conditions are met to ensure the resident is protected from medication errors:

(a) The medications are delivered in a unit of use compatible with the established system of the facility for dispensing drugs; and

(b) The medications are delivered in a timely manner to prevent interruption of dose schedule.

NEW SECTION

WAC 388-107-0340 Prescribed medication authorizations. (1) Before the enhanced services facility may provide medication administration to a resident for prescribed medications, the enhanced services facility must have one of the following:

(a) A prescription label completed by a licensed pharmacy;

(b) A written order from the prescriber;

(c) A facsimile or other electronic transmission of the order from the prescriber; or

(d) Written documentation by a nurse of a telephone order from the prescriber.

(2) The documentation required above in subsection (1) of this section must include the following information:

(a) The name of the resident;

(b) The name of the medication;

(c) The dosage and dosage frequency of the medication; and

(d) The name of the prescriber.

NEW SECTION

WAC 388-107-0350 Medication refusal. (1) When a resident who is receiving medication administration services from the enhanced services facility chooses to not take his or her medications, the enhanced services facility must:

(a) Respect the resident's right to choose not to take medication;

(b) Document the time, date and medication the resident did not take;

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The enhanced services facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the enhanced services facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The enhanced services facility documents such directions; and

(c) The enhanced facility is able to fully comply with such directions.

NEW SECTION

WAC 388-107-0360 Medication refusal—Antipsychotics. (1) When a resident who is being administered antipsychotic medication, chooses to not take his or her medications after two or three attempts, the enhanced services facility must:

(a) Respect the resident's right to choose not to take medication;

(b) Document the time, date and medication the resident did not take; and

(c) Notify the physician within eight hours of the refusal.

(2) The enhanced services facility cannot give the antipsychotic medication in an override of the resident's refusal.

NEW SECTION

WAC 388-107-0370 Treatment services. The enhanced services facility must:

(1) Provide for diagnostic and therapeutic services prescribed by the attending clinical staff that meet all of the resident needs identified in the individual treatment plan, to include mental health and chemical dependency treatment;

(2) Ensure that each resident's individual treatment plan has interventions for behavioral support in accordance with WAC 388-107-0160.

(3) Ensure that all services are provided by specific program professionals, such as mental health professionals and chemical dependency professionals.

NEW SECTION

WAC 388-107-0380 Use of psychopharmacologic medications. (1) The enhanced services facility must ensure that each resident is free from psychopharmacologic drugs used for discipline, to restrain, or for convenience of the staff.

(2) The facility must ensure that when a psychopharmacologic medication is used the resident assessment indicates that the use is necessary to treat the resident's medical symptoms.

NEW SECTION

WAC 388-107-0390 Use of routine psychopharmacologic medications. When the resident is using a psychopharmacological drug on a routine basis, the facility must ensure that the:

(1) Drug is prescribed by a physician or health care professional with prescriptive authority;

(2) Resident's individual treatment plan includes strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;

(3) Changes in medication only occur when the prescriber decides it is medically necessary;

(4) The resident's record includes documentation about the specific symptom or behavior that caused the physician to order the medication and what the resident needs to be able to do or stop doing in order to discontinue the medication.

(5) Documentation includes that the resident, guardian or legal representative, if any, was informed of the need for the psychopharmacologic medication.

NEW SECTION

WAC 388-107-0400 Use of as needed psychopharmacologic medications. If the physician has ordered an as-needed psychopharmacologic medication for a resident, the facility must ensure that the:

(1) Order details the circumstances under which the medication may be used and the medication is given only as specifically ordered;

(2) Resident's individual treatment plan includes behavioral intervention strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;

(3) Documentation in the resident record is done on the specific symptom or behavior that caused the need for the medication and what the results of the use is; and

(4) Documentation includes that the resident, guardian or legal representative, if any, was informed of the need for the medication.

NEW SECTION

WAC 388-107-0410 Management of escalating behaviors. (1) An enhanced services facility must have a specific procedure for de-escalating, preventing and redirecting aggressive and challenging behavior. This protocol must always be the first approach and strategy in resolving behavioral issues. The protocol must include:

(a) Training on prevention of escalation of behavior before it reaches the stage of physical assault;

(b) Techniques for staff to use in response to challenging client behaviors;

(c) Evaluation of the safety of the physical environment;

(d) Issues of respect and dignity of the resident; and

(e) Use of the least restrictive physical and behavioral interventions depending upon the situation;

(2) If the facility uses holding techniques as a last resort to physically restrain residents in emergency situations and as part of behavioral intervention protocols, the facility must:

(a) Use other established resident-specific behavioral interventions first to attempt to de-escalate the situation;

(b) Limit the holding technique to specific emergent situations where behavioral interventions have not been successful in de-escalating a situation and the resident is at imminent risk of harm to self or others due to aggressive behavior;

(c) Limit the time used to only until the arrival of emergency personnel;

(d) Release residents from the holding technique as soon as possible;

(e) Instruct observers on how to support signs of:

(i) Distress by the client; and

(ii) Fatigue by the staff.

(f) Document:

(i) The reason for use of the holding technique;

(ii) Other behavioral interventions attempted prior to the use of the holding technique;

(iii) The duration of the use of the holding technique; and

(iv) The condition of the resident at the time of release from the holding technique.

Restraints

NEW SECTION

WAC 388-107-0420 Mechanical restraints. The enhanced services facility must ensure:

(1) Each resident's right to be free from mechanical restraints used for discipline, behavioral intervention, or staff convenience;

(2) That mechanical restraints are only used for medical purposes; for example to prevent the resident from pulling out a catheter, tube or stitches;

(3) That before using the mechanical restraint, less restrictive alternatives have been tried and found not effective and this has been documented in the resident record;

(4) That before mechanical restraints are used, the resident has been assessed as needing the restraint to treat the emergent medical symptoms and to prevent the resident from self-harm;

(5) That if physical restraints are used, the restraints are applied and immediately supervised on-site by a:

(a) Licensed registered nurse;

(b) Licensed practical nurse; or

(c) Licensed physician; and

(d) For the purposes of this subsection, immediately supervised means that the licensed person is in the facility and quickly and easily available;

(6) When any mechanical restraint is used per (2) above:

(a) A staff person is in the presence of the resident at all times when the restraint is in use;

(b) A physician's order is obtained within eight hours;

(c) The order includes treatments to assist in resolving the emergency situation and eliminating the need for the restraint; and

(d) The use of the mechanical restraint is documented:

(i) On the specific medical issue that caused the need for restraint and what the resident needs to do or stop doing in order to discontinue the restraint; and

(ii) That the resident, guardian or legal representative, if any, was informed of the need for restraint.

Food Services

NEW SECTION

WAC 388-107-0430 Food services. The enhanced services facility must provide or contract out food services for residents. If the facility chooses to contract out the food service, the contracted services must meet all of the applicable food codes and requirements.

1) The enhanced services facility must:

(a) Provide a minimum of three meals a day;

(b) Provide snacks;

(i) Between meals and in the evening at regular intervals; and

(ii) With no more than fourteen hours between the evening meal and breakfast, unless the enhanced services facility provides a nutritious snack after the evening meal and before breakfast.

(c) Provide access to fluids and snacks at all times;

(d) Provide sufficient time and staff support for residents to consume meals;

(e) Ensure all menus:

(i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (h) of this subsection;

(ii) Indicate the date, day of week, month and year;

(iii) Include all food and snacks served that contribute to nutritional requirements;

(iv) Are kept at least six months;

(v) Provide a variety of foods;

(vi) Provide foods at safe and appropriate temperatures; and

(vii) Are not repeated for at least three weeks, except that breakfast menus in enhanced services facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(f) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC regarding food service;

(g) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

(ii) Individual preferences to the extent reasonably possible.

(h) Substitute foods of equal nutrient value, when changes in the current day's menu are necessary, and record changes on the original menu;

(i) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The enhanced services facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

(j) Develop, make known to residents, and implement a process for residents to express their views and comment on the food services; and

(k) Maintain a dining area or areas approved by the department with a seating capacity for seventy-five percent or more of the residents per meal setting, or ten square feet times the licensed resident bed capacity, whichever is greater.

(2) The enhanced services facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The enhanced services facility must ensure the diet manual is:

(i) Available to and used by staff persons responsible for food preparation;

(ii) Approved by a dietitian; and

(iii) Reviewed and updated as necessary or at least every five years.

(b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

(3) The enhanced services facility may provide to a resident at his or her request and as agreed upon in the resident's comprehensive individual treatment plan, non-prescribed:

(a) Modified or therapeutic diets; and

(b) Nutritional concentrates or supplements.

(4) The enhanced services facility must have a means for those residents whose individual treatment plan indicates they have the ability to make or select their own snacks and beverages an opportunity to do so without having to ask a staff member for assistance.

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.

Infection Control

NEW SECTION

WAC 388-107-0440 Infection control system. (1) The enhanced services facility must:

(a) Establish and maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection;

(b) Prohibit any employee with a communicable disease or infected skin lesion from direct contact with residents or their food, if direct contact could transmit the disease; and

(c) Require staff to wash their hands after each direct resident contact for which hand-washing is indicated by accepted professional practice.

(2) Under the infection control system, the enhanced services facility must:

(a) Investigate, control and prevent infections in the facility;

(b) Decide what procedures should be applied in individual circumstances; and

(c) Maintain a record of incidence of infection and corrective action taken.

(3) Enhanced services facility personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(4) The enhanced services facility must develop and implement effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal.

(5) The enhanced services facility must provide areas, equipment, and supplies to implement an effective infection control program and ensure:

(a) Ready availability of hand cleaning supplies and appropriate drying equipment or material at each sink;

(b) Safe use of disposable and single service supplies and equipment;

(c) Effective procedures for cleaning, disinfecting or sterilizing according to equipment use;

(d) Chemicals and equipment used for cleaning, disinfecting, and sterilizing, including chemicals used to launder personal clothing, are used in accordance with manufacturer's directions and recommendations; and

(e) Safe and effective procedures for disinfecting all therapy tubs and bathing and shower facilities between each resident use.

NEW SECTION

WAC 388-107-0450 Early identification and management of individuals with active tuberculosis. (1) The enhanced services facility must develop and implement policies and procedures that comply with nationally recognized tuberculosis standards set by the Centers for Disease Control, and applicable state law. Such policies and procedures include, but are not limited to, the following:

(a) Evaluation of any resident or employee with symptoms suggestive of tuberculosis whether tuberculosis test results were positive or negative;

(b) Identifying, and following up on, residents and personnel with suspected or confirmed tuberculosis, in a timely manner; and

(c) Identifying, and following up on, volunteers with symptoms suggestive of tuberculosis.

(2) The enhanced services facility must comply with chapter 49.17 RCW, Washington Industrial Safety and Health Act (WISHA) requirements to protect the health and safety of employees.

NEW SECTION

WAC 388-107-0460 Tuberculosis—Testing—Required. (1) The enhanced services facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

(2) For purposes of WAC 388-107-0460 through 388-107-0540, "staff person" means any enhanced services facility employee or temporary employee of the enhanced services facility, excluding volunteers and contractors.

NEW SECTION

WAC 388-107-0465 Testing method—Required. The enhanced services facility must ensure that all tuberculosis testing is done through either:

(1) Tuberculin skin test with results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a qualified professional; or

(2) An FDA approved blood test for tuberculosis.

NEW SECTION

WAC 388-107-0470 Tuberculosis—No testing. The enhanced services facility is not required to have a staff person tested for tuberculosis if the staff person has:

(1) A documented history of a previous positive tuberculin skin test;

(2) A documented history of a previous positive FDA approved blood test; or

(3) Documented evidence of:

(a) Adequate therapy for active disease; or

(b) Completion of treatment for latent tuberculosis infection.

NEW SECTION

WAC 388-107-0480 Tuberculosis—One test. The enhanced services facility is only required to have a staff person take one tuberculosis test if the staff person has any of the following:

(1) A documented history of a negative result from a previous two-step tuberculin skin test; or

(2) A documented negative result from one tuberculin skin test in the previous twelve months; or

(3) A documented negative FDA approved TB blood test.

NEW SECTION

WAC 388-107-0490 Tuberculosis—Two-step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the enhanced services facility choosing to do skin testing must ensure that each staff person has the following two-step tuberculin skin testing:

(1) An initial tuberculin skin test within three days of employment; and

(2) A completed two-step tuberculin skin test within four weeks of employment.

NEW SECTION

WAC 388-107-0500 Tuberculosis—Positive test result. When there is a positive result to tuberculin skin or FDA approved blood testing, the enhanced services facility must:

(1) Ensure that the staff person has a chest radiograph within seven days of a positive tuberculosis test result;

(2) Ensure each resident or staff person with a positive test result undergoes ongoing observation for signs and symptoms of tuberculosis;

(3) Follow the recommendation of the resident or staff person's health care provider; and

(4) Annually screen employees and residents for symptoms.

NEW SECTION

WAC 388-107-0510 Tuberculosis—Negative test result. The enhanced services facility may be required by the health care provider or licensing authority to ensure that staff persons with negative test results have follow-up testing in certain circumstances, such as:

(1) After exposure to active tuberculosis; or

(2) When tuberculosis symptoms are present.

NEW SECTION

WAC 388-107-0520 Tuberculosis—Declining a skin test. The enhanced services facility must ensure that a staff person take an FDA approved blood test for tuberculinosis if they decline the tuberculin skin test.

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

NEW SECTION

WAC 388-107-0530 Tuberculosis—Reporting—Required. The enhanced services facility must:

(1) Report any staff person or resident with tuberculosis symptoms or a positive chest radiograph to the appropriate health care provider in accordance with chapter 246-101 WAC;

(2) Follow the infection control and safety measures ordered by the staff person's health care provider;

(3) Institute appropriate infection control measures;

(4) Apply living or work restrictions where residents or staff persons are, or may be, infectious and pose a risk to other residents and staff persons; and

(5) Ensure that staff persons caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in chapter 296-842 WAC.

NEW SECTION

WAC 388-107-0540 Tuberculosis—Test records. The enhanced services facility must:

(1) Keep the records of tuberculin skin test results, reports of chest radiograph findings, and any physician or health care provider orders in the enhanced services facility;

(2) Make the records readily available to the appropriate health provider and licensing agency;

(3) Retain the records for at least two years after the date the staff person either quits or is terminated; and

(4) Provide the staff person with a copy of his/her test results.

Administration

NEW SECTION

WAC 388-107-0550 Contracted basic services. If the provider does not intend to provide basic services in-house, the provider must contract with an outside source to provide those services. The provider must ensure that the contracted services, at a minimum, meet applicable state, local, and licensing standards. Basic services include, but are not limited to:

(1) Housekeeping services;

(2) Food services; and

(3) Laundry services.

NEW SECTION

WAC 388-107-0560 Resident records—Clinical records. (1) The enhanced services facility must:

(a) Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(b) Safeguard clinical record information against alteration, loss, destruction, and unauthorized use; and

(c) Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

(i) Transfer to another health care institution;

(ii) Law; or

(iii) The resident.

(2) The enhanced services facility must ensure the clinical record of each resident includes at least the following:

(a) Resident identification and sociological data, including the name and address of the individual or individuals the resident designates as significant;

(b) Medical information;

(c) Physician's orders;

(d) Assessments;

(e) Individual treatment plans;

(f) Services provided;

(g) Progress notes;

(h) Medications administered;

(i) Consents, authorizations, releases;

(j) Allergic responses;

(k) Laboratory, X-ray, and other findings; and

(l) Other records as appropriate.

NEW SECTION

WAC 388-107-0570 Resident records—System. (1) The enhanced services facility must:

(a) Designate an individual responsible for the record system who:

(i) Has appropriate training and experience in clinical record management; or

(ii) Receives consultation from a qualified clinical record practitioner, such as a registered health information administrator or registered health information technician.

(b) Make all records available to authorized representatives of the department for review and duplication as necessary; and

(c) Maintain the following:

(i) A master resident index having a reference for each resident including the health record number, if applicable; full name; date of birth; admission dates; and discharge dates; and

(ii) A chronological census register, including all admissions, discharge, deaths and transfers, and noting the receiving facility. The enhanced services facility must ensure the register includes discharges and transfers to other treatment facilities in excess of twenty-four hours.

(2) The enhanced services facility must ensure the clinical record of each resident:

(a) Is documented and authenticated accurately, promptly and legibly by individuals giving the order, making the observation, performing the examination, assessment, treatment or providing the care and services. **"Authenticated"** means the authorization of a written entry in a record by signature, including the first initial and last name and title, or a unique identifier allowing identification of the responsible individual; and:

(i) Documents from other health care facilities that are clearly identified as being authenticated at that facility will be considered authenticated at the receiving facility; and

(ii) The original or a durable, legible, direct copy of each document will be accepted.

(b) Contains appropriate information for a deceased resident including:

(i) The time and date of death;

(ii) Apparent cause of death;

(iii) Notification of the physician and appropriate resident representative; and

(iv) The disposition of the body and personal effects.

NEW SECTION

WAC 388-107-0580 Resident records—Maintenance and retention. (1) In cases where the enhanced services facility maintains records by computer rather than hard copy, the facility must:

(a) Have in place safeguards to prevent unauthorized access; and

(b) Provide for reconstruction of information.

(2) The enhanced services facility must:

(a) Retain health records for a period of no less than eight years following the most recent discharge of the resident;

(b) In the event of a change of ownership, provide for the orderly transfer of clinical records to the new licensee;

(c) In the event an enhanced services facility ceases operation, make arrangements prior to cessation, as approved by the department, for preservation of the clinical records. The enhanced services facility licensee must provide a plan for preservation of clinical records to the department's designated local office no later than seven days after the date of notice of the facility closure unless an alternate date has been approved by the department; and

(d) Provide a resident access to all records pertaining to the resident as required.

Reporting Requirements

NEW SECTION

WAC 388-107-0590 Reporting abuse and neglect. (1) The enhanced services facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Long-Term Support Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

(2) The enhanced services facility must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

NEW SECTION

WAC 388-107-0600 Reporting significant change in a resident's condition. (1) The enhanced services facility must consult with the resident's representative, the resident's physician, the resident's department case manager, and other individuals designated by the resident within 24 hours when:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility;

(c) The resident's condition improved and the resident no longer needs the care and services provided by the enhanced services facility; or

(d) The resident dies.

(2) Whenever any of the conditions in subsection (1) of this section occurs, the enhanced services facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

(3) In case of a resident's death, the enhanced services facility must notify the coroner if required by RCW 68.50.-010.

NEW SECTION

WAC 388-107-0610 Reporting fires and incidents. The enhanced services facility must immediately report to the department:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the enhanced services facility;

(2) Any missing resident, once the initial search for the resident is completed and 911 is notified;

(3) Any unusual incident that requires implementation of the enhanced services facility's disaster plan, including any evacuation of all or part of the residents to another area of the enhanced services facility or to another address; and

(4) Circumstances which threaten the enhanced services facility's ability to ensure continuation of services to residents.

NEW SECTION

WAC 388-107-0620 Retaliation or discrimination prohibited. (1) The enhanced services facility must not discriminate or retaliate in any manner against a resident or employee in its enhanced services facility who has initiated or participated in any action or proceeding authorized under enhanced services facility licensing law.

(2) For purposes of this chapter, **"retaliation"** or **"discrimination"** against a resident means an act including, but not limited to:

(a) Verbal or physical harassment or abuse;

(b) Any attempt to expel the resident from the facility;

(c) Non-medically indicated social, dietary, or mobility restrictions;

(d) Lessening of the level of care when not medically appropriate;

(e) Non-voluntary relocation within an enhanced services facility without appropriate medical, psychosocial, or nursing justification;

(f) Neglect or negligent treatment;

(g) Withholding privileges;

(h) Monitoring resident's phone, mail or visits without resident's permission;

(i) Withholding or threatening to withhold food or treatment unless authorized by a terminally ill resident or the resident's representative;

(j) Persistently delaying responses to resident's request for services or assistance; or

(k) Infringement on a resident's rights described in this chapter.

(3) For purposes of this chapter, **"retaliation"** or **"discrimination"** against an employee means an act including, but not limited to:

(a) Harassment;

(b) Unwarranted firing;

(c) Unwarranted demotion;

(d) Unjustified disciplinary action;

(e) Denial of adequate staff to perform duties;

(f) Frequent staff changes;

(g) Frequent and undesirable office changes;

(h) Refusal to assign meaningful work;

(i) Unwarranted and unsubstantiated report of misconduct under Title 18 RCW;

(j) Unsubstantiated letters of reprimand;

(k) Unsubstantiated unsatisfactory performance evaluations;

(l) Denial of employment;

(m) A supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower; or

(n) Workplace reprisal or retaliatory action as defined in RCW 74.34.180 (3)(b).

(4) If, within one year of the complaint by or on behalf of a resident, the resident is involuntarily discharged from the enhanced services facility, or is subjected to any type of discriminatory treatment, there will be a presumption that the action was in retaliation for the filing of the complaint. Under these circumstances, the enhanced services facility will have the burden of establishing that the action was not retaliatory, in accordance with RCW 74.34.180(2).

Training Requirements

NEW SECTION

WAC 388-107-0630 Training and home care aide certification requirements. (1) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant program are exempt from long-term care worker training requirements.

(2) Continuing education requirements are outlined in chapter 388-112 WAC; registered nurses and licensed practical nurses are exempt from the long-term care worker continuing education requirement.

(3) The enhanced services facility must ensure staff persons meet training requirements in effect on the date hired, including requirements in chapter 388-112 WAC, unless exempt under RCW 18.88B.041.

(4) The enhanced services facility must ensure all enhanced services facility administrators, or their designees, and caregivers who are not exempt under subsection (1) of this section meet the long-term care worker training requirements of chapter 388-112 WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

(c) Specialty for dementia and, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(5) The enhanced services facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

(6) The enhanced services facility must ensure the following staff obtain home care aide certification, unless exempt under WAC 246-980-070:

(a) All long-term care workers, within two hundred days of hire;

(b) All enhanced services facility applicants, before licensure;

(c) All enhanced services facility administrators within two hundred days of hire, and

(d) Any other staff who will provide direct care and services to residents.

NEW SECTION

WAC 388-107-0640 Staff development trainings. (1) The enhanced services facility must have a staff development program that is under the direction of a designated registered nurse or licensed practical nurse or mental health professional.

(2) The enhanced services facility must:

(a) Ensure each employee receives initial orientation to the facility and its policies and is initially assigned only to duties for which the employee has demonstrated competence;

(b) Ensure all employees receive appropriate in-service and continuing education to maintain a level of knowledge appropriate to, and demonstrated competence in, the performance of ongoing job duties consistent with the principle of assisting the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. To this end, the enhanced services facility must:

(i) Assess the specific training needs of each employee and address those needs;

(ii) Determine the special needs of the enhanced services facility's resident population which may require training emphasis; and

(iii) Ensure that each employee is trained on de-escalating challenging behaviors, including the use of a manual technique intended to interrupt or stop a behavior from occurring.

(c) Comply with other applicable training requirements, such as, but not limited to, the blood borne pathogen standard.

NEW SECTION

WAC 388-107-0650 Specialized training. (1) The enhanced services facility must ensure all staff who have any interaction with the residents successfully complete the mental health and dementia specialized trainings, consistent with chapter 388-112 WAC, prior to working in the enhanced services facility.

(2) The facility must ensure all staff who have interaction with the residents complete any other specialty trainings to meet the needs of the residents being served, such as developmental disabilities.

NEW SECTION

WAC 388-107-0660 Continuing education requirements for the home care aide certified staff. All home care aide certified staff must have ten of their twelve hours of annual continuing education cover relevant education regarding the population served in the enhanced services facility.

NEW SECTION

WAC 388-107-0670 In-service education requirements for nursing assistant certified staff. All nursing assistant certified staff must have ten of their twelve hours of annual continuing education cover relevant education regarding the population served in the enhanced services facility.

NEW SECTION

WAC 388-107-0680 Quarterly staff education requirements. In addition to the annual continuing education requirements for individual staff, the enhanced services facility must provide three hours of training per quarter relevant to the needs of the population being served.

NEW SECTION

WAC 388-107-0690 Facility-based trainers. If the enhanced services facility provides continuing education, in-service education or quarterly staff education, the educators must be approved by the department prior to educational intervention, in accordance with chapter 388-112 WAC.

Physical Plant Basic Requirements

NEW SECTION

WAC 388-107-0700 General. (1) The Department of Health Construction Review Services will review the following general, code, program submittal and minimum requirements to ensure that the facility is in compliance with enhanced services facility physical plant basic requirements.

(2) The enhanced services facility must be on the ground floor.

(3) For the purposes of the physical plant sections, the use of the term facility also means applicant where applicable.

(4) The department may not exempt any physical environment requirements established in law but may exempt the enhanced services facility from meeting other specific requirements related to the physical environment if the department determines the exemption will not:

(a) Jeopardize the health or safety of residents;

(b) Adversely affect the residents' quality of life; or

(c) Change the fundamental nature of the enhanced services facility operation into something other than an enhanced services facility.

(5) An enhanced services facility wishing to request an exemption must submit a written request to the department, including:

(a) A description of the requested exemption; and

(b) The specific WAC requirement for which the exemption is sought.

(6) If a physical plant requirement, such as an isolation or seclusion room, is not included or addressed in this chapter, it is not allowed.

NEW SECTION

WAC 388-107-0710 Conversion of a currently licensed facility to an enhanced services facility. (1) If the department licenses part or all of a currently licensed nursing home under chapter 18.51 RCW, assisted living facility under chapter 18.20 RCW, or adult family home under chapter 70.128 RCW, as an enhanced services facility, the facility is deemed to meet the applicable state and local rules, regulations, permits, and code requirements, with the exceptions of subsections (2), (3), (4) and (5) of this section.

(2) If the facility's previous construction has the potential to jeopardize resident health and safety, the department may require compliance with enhanced services facility physical plant new construction rules.

(3) Only portions of an existing building that are on the ground floor can be converted for use as an enhanced services facility.

(4) If the facility does construction to meet enhanced services facility requirements, that construction has to be reviewed and approved by construction review services and applicable local and state building officials.

(5) The enhanced services facility must also meet specific new construction requirements related to the safety of any residents with complex needs that the facility is choosing to serve.

(6) All other facilities or new facilities must meet all enhanced services facility new construction requirements, including the applicable state and local rules, regulations, permits, and code requirements.

NEW SECTION

WAC 388-107-0720 Types of new construction. New construction includes but is not limited to:

(1) New structures:

(a) A new building to be licensed as an ESF; or

(b) An addition to a building currently licensed as an ESF.

(2) Existing buildings:

(a) Conversion of another building to an ESF;

(b) Change in the use of space for access by residents within an existing ESF; and

(c) Alterations, additions, or modifications of an existing facility including but not limited to:

(i) Physical structure;

(ii) Electrical fixtures or systems;

(iii) Mechanical equipment or systems;

(iv) Fire alarm fixtures or systems;

(v) Fire sprinkler fixtures or systems;

(vi) Wall coverings 1/28 thick or thicker;

(vii) Floor coverings; or

(viii) Kitchen or laundry equipment.

(d) A change in the department-approved use of an existing facility or portion of a facility; and

(e) An existing building or portion thereof to be converted for the approved use.

NEW SECTION

WAC 388-107-0730 Applicable codes—New construction. New construction of enhanced services facilities must:

(1) Through its design, construction and necessary permits demonstrate compliance with this chapter, the following codes and local jurisdiction standards.

(2) Obtain all local permits before construction and maintain on file at the facility.

(3) Comply with the International Building Code, and International Building Code Standards, as published by the International Conference of Building Officials as amended and adopted by the Washington state building code council and published as chapter 51-50 WAC, or successor laws.

(4) Identify the planned types of residents served at the point of initial licensure to determine occupancy consistent with nursing homes, assisted living facilities or adult family homes;

(5) Comply with the International Mechanical Code, including chapter 22, Fuel Gas Piping, Appendix B, as published by the International Conference of Building Officials and the International Association of Plumbing and Mechanical Officials as amended and adopted by the Washington state building code council and published as chapter 51-52 WAC, or successor laws;

(6) Comply with the International Fire Code, and International Fire Code Standards, as published by the International Conference of Building Officials and the Western Fire Chiefs Association as amended and adopted by the Washington state building code council and published as chapter 51-54 WAC, or successor laws;

(7) Comply with the Uniform Plumbing Code, and Uniform Plumbing Code Standards, as published by the International Association of Plumbing and Mechanical Officials, as amended and adopted by the Washington state building code council and published as chapters 51-56 and 51-57 WAC, or successor laws;

(8) Ensure that all electrical wiring complies with state and local electrical codes including chapter 296-46B WAC and the National Electric Code of the National Fire Protection Association (NFPA-70) as adopted by the Washington state department of labor and industries.

(9) Ensure conformance to the approved plans during construction.

NEW SECTION

WAC 388-107-0740 Required review of building plans. (1) The facility must submit plans to construction review services as directed by the department of health construction review services for approval prior to beginning any construction or conversion of an existing facility or a portion of an existing facility. The approved plans must be conformed to during construction.

(2) The facility must notify construction review services of all planned new construction regarding the facility prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as a facility;

(b) An addition of, or modification or alteration to an existing facility, including, but not limited to, the facility's:

(i) Physical structure;

(ii) Electrical fixtures or systems;

(iii) Mechanical equipment or systems;

(iv) Fire alarm fixtures or systems;

(v) Fire sprinkler fixtures or systems;

(vi) Wall coverings 1/28 thick or thicker;

(vii) Floor coverings; or

(viii) Kitchen or laundry equipment.

(c) A change in the department-approved use of an existing facility or portion of a facility; and

(d) An existing building or portion thereof to be converted for the approved use.

(3) The facility does not need to notify construction review services of the following:

(a) Repair or maintenance of equipment, furnishings or fixtures;

(b) Replacement of equipment, furnishings or fixtures with equivalent equipment, furnishings, or fixtures;

(c) Repair or replacement of damaged construction if the repair or replacement is performed according to construction documents approved by construction review services within eight years preceding the current repair or replacement;

(d) Painting; or

(e) Cosmetic changes that do not affect resident activities, services, or care and are performed in accordance with the current edition of the building code.

NEW SECTION

WAC 388-107-0750 Document submittal requirements. The facility must:

(1) Provide one copy of the functional program;

(2) Provide an analysis of likely adverse impacts on current residents and plans to eliminate or mitigate such adverse impacts;

(3) Provide for the health, safety, and comfort of residents during construction projects;

(4) Ensure that construction documents include two copies of the following:

(a) Drawings prepared, stamped, and signed by an architect licensed by the state of Washington under chapter 18.08 RCW. The services of a consulting engineer licensed by the state of Washington may be used for the various branches of the work, if appropriate; and

(b) Drawings with coordinated architectural, mechanical, and electrical work drawn to scale showing complete details for construction, including:

(i) Site plan(s) showing streets, driveways, parking, vehicle and pedestrian circulation, utility line locations, and location of existing and new buildings;

(ii) Dimensioned floor plan(s) with the function of each room and fixed/required equipment designated;

(iii) Elevations, sections, and construction details;

(iv) Schedule of floor, wall, and ceiling finishes;

(v) Schedules of doors and windows – sizes and type, and door finish hardware;

(vi) Mechanical systems – plumbing and heating/venting/air conditioning; and

(vii) Electrical systems, including lighting, power, and communication/notification systems.

(c) Specifications that describe with specificity the workmanship and finishes;

(d) Shop drawings and related equipment specifications for:

(i) An automatic fire sprinkler system when required by other codes; and

(ii) An automatic fire alarm system when required by other codes.

(5) Submit addenda, change orders, construction change directives or any other deviation from the approved plans prior to their installation; and

(6) Provide a written construction project completion notice to the Department of Health Construction Review Services indicating:

(a) The completion date; and

(b) The actual construction cost.

NEW SECTION

WAC 388-107-0760 Functional program. The facility must implement a functional program. The functional program must clearly define the level, type and scope of care provided. The functional program will cover, but is not limited to the following:

(1) Scope of the project;

(2) Type of residents to be admitted to the facility;

(3) Services offered;

(4) Activities provided;

(5) Transportation;

(6) Staffing;

(7) Emergency and disaster planning;

(8) Type of rooms;

(9) Resident rooms;

(10) Outdoor spaces;

(11) Laundry services;

(12) Janitorial services;

(13) Food services;

(14) Communication systems;
(15) Security systems; and
(16) Other components.

Common Elements

NEW SECTION

WAC 388-107-0770 Environment of care. The facility must ensure that:

(1) The facility is designed to provide the level of security appropriate for the specific type of service or program provided as well as the age level, acuity, and risk of the residents served (e.g., geriatric, acute psychiatric, or forensic).

(2) Facility spaces accessible to residents must be designed to minimize locations where residents are out of the line of sight of staff.

(3) All rooms with lockable doors, including but not limited to resident sleeping rooms and bathrooms, have a readily accessible means of rapid access for all staff.

(4) Perimeter security addresses elopement prevention, prevention of contraband smuggling, visitor access control, and exit process and procedures.

(5) Openings in the perimeter security system (e.g., windows, doors, and gates) are controlled by locks (manual, electric, or magnetic) when required by the functional program.

NEW SECTION

WAC 388-107-0780 Electronic monitoring equipment—Audio monitoring and video monitoring. (1) Except as provided in this section or in WAC 388-107-0790, the facility must not use the following in the facility:

(a) Audio monitoring equipment; or

(b) Video monitoring equipment if it includes an audio component.

(2) The facility may video monitor and video record activities in the facility, without an audio component, only in the following areas:

(a) Entrances and exits if the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather.

(b) Outdoor areas not commonly used by residents; and

(c) Designated smoking areas, 25 feet away from the facility, subject to the following conditions:

(i) Residents are assessed as needing supervision for smoking;

(ii) A staff person watches the video monitor at any time the area is used by such residents;

(iii) The video camera is clearly visible;

(iv) The video monitor is not viewable by the general public; and

(v) The facility notifies all residents in writing of the video monitoring equipment.

NEW SECTION

WAC 388-107-0790 Electronic monitoring equipment—Resident requested use. (1) The facility must not use audio or video monitoring equipment to monitor any resident unless:

(a) The resident has requested the monitoring; and

(b) The monitoring is only used in the sleeping room of the resident who requested the monitoring.

(2) If the resident requests audio or video monitoring, before any electronic monitoring occurs the facility must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(b) The resident has identified a threat to the resident's health, safety or personal property; and

(c) The resident and the facility have agreed upon a specific duration for the electronic monitoring documented in writing.

(3) The facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing signed and dated by the resident.

(4) The facility must immediately stop electronic monitoring if the:

(a) Resident no longer wants electronic monitoring; or

(b) Resident becomes unable to give consent.

(5) For the purposes of consenting to video electronic monitoring, without an audio component, the term "resident" includes the resident's decision maker.

(6) For the purposes of consenting to audio electronic monitoring, the term "resident" includes only:

(a) The resident residing in the facility; or

(b) The resident's court-appointed guardian or attorney-in-fact who has obtained a court order specifically authorizing the court-appointed guardian or attorney-in-fact to consent to audio electronic monitoring of the resident.

(7) If the resident's decision maker consents to audio electronic monitoring as specified in subsection (6) above, the facility must maintain a copy of the court order authorizing such consent in the resident's record.

NEW SECTION

WAC 388-107-0800 Equipment. The facility must have adequate equipment, supplies, and space to carry out all functions and responsibilities of the facility.

NEW SECTION

WAC 388-107-0810 Resident room. The facility must ensure that each resident sleeping room:

(1) Meets the following standards:

(a) Maximum capacity of one resident.

(b) May be locked by the resident:

(i) Unless otherwise indicated by an identified need in the Individual Treatment Plan; and

(ii) All staff have a readily accessible means of unlocking the room when the door is locked.

(c) Minimum clear floor area of 100 square feet.

(d) Has one or more outside windows that:

(i) If used for ventilation, are easily opened;

(ii) Have break-away adjustable shades, blinds, or equivalent installed for visual privacy and are designed to meet the safety needs of the resident; and

(2) Is adjacent to bathing and toilet facilities;

(3) Is designed to offer visual privacy from casual observation by other residents and visitors. The design for privacy must not restrict resident access to the entrance, hand-washing station, or toilet.

(4) Is accessible, clean, and well-maintained with sufficient space, light, and comfortable furnishings for sleeping and personal activities including, but not limited to:

(a) A minimum of a three-foot clear access aisle from the entry door, along at least one side of the bed, and in front of all storage equipment;

(b) Enough room for medical equipment and for a resident to move about freely with mobility aides, such as wheelchairs; and

(c) Direct access to a hallway, living room, lounge, the outside, or other common use area without going through a laundry or utility area, a bath or toilet room, or another resident's bedroom.

(5) Is equipped with:

(a) One or more waste containers;

(b) Furniture appropriate for the age and physical condition of each resident, including but not necessarily limited to:

(i) A chair, which may be used in either the bedroom or a group room interchangeably; and

(ii) A bed of appropriate length and size that is thirty-six or more inches wide.

NEW SECTION

WAC 388-107-0820 Resident toilet room. The facility will ensure:

(1) Toilet room doors:

(a) Are equipped with keyed locks that allow staff to control access to the toilet room, where indicated by the resident safety risk assessment;

(b) Swing outward or be double-acting; and

(c) For accessible resident toilet rooms, provide space for facility caregivers to transfer residents to the toilet using portable mechanical lifting equipment.

(2) One toilet and hand-washing sink for every four residents, or fraction thereof, with:

(a) Provisions for privacy during toileting, bathing, showering, and dressing;

(b) Separate toilet rooms for each sex if the toilet room contains more than one toilet; and

(c) Separate bathrooms for each sex if the bathroom contains more than one bathing fixture.

(3) Toilet rooms and bathrooms are directly accessible from patient rooms or corridors, without passing through any kitchen, pantry, food preparation, food storage, or dish-washing area or from one bedroom through another bedroom.

(4) Grab bar(s) in non-accessible toilet rooms must be installed to prevent fall and injury based on resident specific needs.

(5) Grab bar(s) in accessible toilet rooms must be installed according to the state building code requirements for accessible toilets.

NEW SECTION

WAC 388-107-0830 Resident bathing facilities. The facility must provide access to a bathtub or shower for every resident. The facility will ensure that bathing facilities are designed and located for resident convenience and privacy. The facility must ensure:

(1) At least one bathing unit for every four residents, or fraction thereof, who are located in a resident room without an adjoining bathroom;

(2) Access to at least one bathing device for immersion;

(3) Access to at least one roll-in shower or equivalent on each resident care unit:

(a) Designed and equipped for unobstructed ease of shower chair entry and use;

(b) With a spray attachment equipped with a backflow prevention device;

(c) One-half inch or less threshold that may be a collapsible rubber water barrier; and

(d) A minimum nominal (rough-framed) size of thirty-six inches by forty-eight.

(4) Resident bathing equipment is smooth, cleanable, and able to be disinfected after each use.

(5) In each bathing unit containing more than one bathing facility:

(a) Each bathtub, shower, or equivalent, is located in a separate room or compartment with three solid walls;

(b) The entry wall may be a break-away "shower" type curtain or equivalent;

(c) The area for each bathtub and shower is sufficient to accommodate a shower chair, an attendant, and provide visual privacy for bathing, drying, and dressing;

(d) All shower and tub surfaces are slip-resistant; and

(e) All bathing areas are constructed of materials that are impervious to water and cleanable.

(6) Common bathing facilities must comply with the state building code requirements for accessible bathing facilities.

(7) Grab bar(s) must be installed to prevent fall and injury in bathing facilities in non-accessible resident rooms.

(8) Grab bar(s) in accessible bathing rooms must be installed according to the state building code requirements for accessible bathing rooms.

NEW SECTION

WAC 388-107-0840 Locks in toilet and bathing facilities. The facility must ensure:

(1) All staff have a readily available means of unlocking lockable toilet facilities and bathrooms from the outside; and

(2) Locks are operable from the inside with a single motion.

NEW SECTION

WAC 388-107-0850 Resident storage. The facility must ensure:

(1) Each resident has, within his or her room, a separate wardrobe (for hanging garments), locker, or closet for storing personal effects.

(2) Shelves for folded garments may be used instead of arrangements for hanging garments if acceptable to the resident.

(3) Adequate storage must be available for a seven-day supply of clothes.

NEW SECTION

WAC 388-107-0860 Resident support spaces. The facility must ensure:

(1) Private space:

(a) For the use of individual residents, family, and caregivers to discuss the specific resident's needs or private family matters;

(b) With a minimum clear floor area of 144 square feet; and

(c) Furnished with comfortable seating to accommodate several people.

(2) If a room for resident grooming is provided, the room will include:

(a) Spaces for hair-washing station(s), hair clipping and hair styling, and other grooming needs.

(b) A hand-washing station, mirror, work counter(s), storage shelving, and sitting area(s) for resident.

(3) Resident support spaces have access to a common-use toilet facility.

Common Areas

NEW SECTION

WAC 388-107-0870 Common areas. The facility must ensure that all residents have access to common areas throughout the facility including, but not limited to, dining rooms, day rooms, and activity areas.

NEW SECTION

WAC 388-107-0880 Dining, dayrooms, and resident activity areas. (1) The facility must provide one or more rooms designated for resident dining and activities that is:

(a) Well lighted;

(b) Well ventilated;

(c) Adequately furnished;

(d) Large enough to accommodate all residents; and

(e) Large enough to accommodate all resident activities.

(2) The facility must design space for dining rooms, dayrooms, and activity areas for resident convenience and comfort and to provide a homelike environment. The facility must:

(a) Ensure these rooms or areas are exterior rooms with windows that have a maximum sill height of thirty-six inches;

(b) Provide space for dining, day use, and activities with a minimum of one hundred fifty square feet or combined total of thirty square feet for each licensed bed, whichever is greater;

(c) Design any multipurpose rooms to prevent program interference with each other; and

(d) Provide adjoining or adjacent storage spaces for all activity and recreational equipment and supplies.

NEW SECTION

WAC 388-107-0890 Outdoor recreation space and walkways. (1) A facility must provide a safe, protected outdoor area for resident use.

(2) The facility must ensure the outdoor area:

(a) Has areas protected from direct sunshine and rain throughout the day;

(b) Is accessible and has walking surfaces which are firm, stable, and free from cracks and abrupt changes with a maximum of one inch between the sidewalk and adjoining landscape areas;

(c) Has sufficient space and outdoor furniture provided with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids;

(d) Contains non-poisonous shrubs, natural foliage, and trees;

(e) Is surrounded by walls or fences at least seventy-two inches high; and

(f) If used as a resident courtyard, the outdoor area must not be used for public or service deliveries.

Support Services

NEW SECTION

WAC 388-107-0900 Laundry. The facility must provide laundry and linen services on the premises, or by contract with a commercial laundry. If laundry services are provided on-site, the facility must ensure that laundry facilities, equipment, handling and processes provide residents with linen and laundered items that are clean, in good repair and adequate to meet the needs of residents. The facility:

(1) Must handle, clean, and store linen according to acceptable methods of infection control, and:

(a) Ensure all staff wear appropriate personal protective equipment and use appropriate infection control practices when handling laundry;

(b) Ensure that damp textiles or fabrics are not left in machines for longer than twelve hours;

(c) Ensure that gross soil is removed before washing and proper washing and drying procedures are used; and

(d) Ensure that contaminated textiles and fabrics are handled with minimum agitation to avoid contamination of air, surfaces and persons.

(2) Must equip the laundry area with:

(a) A utility sink;

(b) A table or counter for folding clean laundry;

(c) At least one washing machine and one clothes dryer; and

(d) Mechanical ventilation to the exterior.

(3) Must use and maintain laundry equipment according to manufacturer's instructions.

(4) Must use washing machines that have a continuous supply of hot water with a temperature of one hundred forty degrees Fahrenheit, or that automatically dispense a chemical sanitizer and detergent or wash additives as specified by the manufacturer, whenever the licensee washes:

(a) Enhanced services facility laundry;

(b) Enhanced services facility laundry combined with residents' laundry into a single load; or

(c) More than one resident's laundry combined into a single load.

(5) May allow residents to wash their individual personal laundry, separate from other laundry, at temperatures below

one hundred forty degrees Fahrenheit provided chemicals suitable for low temperature washing at proper use concentration and according to the cleaning instructions of the textile, fabric or clothing.

(6) Must ventilate laundry rooms and areas to the exterior including areas or rooms where soiled laundry is held for processing by offsite commercial laundry services.

(7) Must locate laundry equipment in rooms other than those used for open food storage, food preparation or food service.

NEW SECTION

WAC 388-107-0910 Janitors closets on resident care units. The facility must ensure:

(1) There is a janitor's closet with a service sink and adequate storage space for housekeeping equipment and supplies.

(2) The janitor's closet meets the ventilation requirements in WAC 388-107-1000.

NEW SECTION

WAC 388-107-0920 Kitchen. The facility must provide food service on the premises or by contract with a commercial kitchen. If the facility provides food service on-site, the facility must ensure food service areas are in compliance with chapter 246-215 WAC, state board of health rules governing food service sanitation. The facility providing on-site food service must:

(a) Ensure food service areas are provided for the purpose of preparing, serving, and storing food and drink;

(b) Ensure food service areas are located to facilitate receiving of food supplies, disposal of kitchen waste, and transportation of food to dining and resident care areas;

(c) Locate and arrange the kitchen to avoid contamination of food, to prevent heat and noise entering resident care areas, and to prevent through traffic;

(d) Conveniently locate a hand-washing sink near the food preparation and dishwashing area, and include a waste receptacle and dispensers stocked with soap and paper towels;

(e) Adequately ventilate, light, and equip the dishwashing room or area for sanitary processing of dishes;

(f) Locate the garbage storage area in a well-ventilated room or an outside area;

(g) Provide space for an office or a desk and files for food service management located central to deliveries and kitchen operations; and

(h) Include housekeeping facilities or a janitor's closet for the exclusive use of food service with a service sink and storage space for housekeeping equipment and supplies.

NEW SECTION

WAC 388-107-0930 Nursing station. The facility must have a kitchenette to give residents access to fluids and snacks, including those of nutritive value, to meet resident wants and needs. The kitchenette will include:

(1) A sink with hot and cold running water;

(2) A soap dispenser; and

(3) A refrigerator.

Building Elements

NEW SECTION

WAC 388-107-0940 Resident safety and suicide prevention. The enhanced services facility must be designed to prevent injury and suicide prevention, with special design considerations to details, finishes, and equipment. The facility must ensure:

(1) Ceilings

(a) In resident bathrooms are secured to prevent resident access. Ceiling systems of a non-secured (non-clipped down) lay-in ceiling tile design are not permitted.

(b) In resident bedrooms and bathrooms, are designed to eliminate tie-off point(s) or at nine feet in height to prevent resident access.

(2) Doors and door hardware:

(a) Doorways are at least 36" wide;

(b) Door swings for private resident bathrooms or shower areas swing out to allow for staff emergency access.

(i) Door closers will not be used unless required by the building code. If required on the resident room door, the closer will be mounted on the public side of the door rather than the private resident's side of the door.

(3) Door hinges:

(a) Are designed to minimize points for hanging (i.e., cut hinge type); and

(b) Are consistent with the level of care for the resident.

(4) Door lever handles are specifically designed anti-ligature hardware.

(5) All hardware has tamper-resistant fasteners.

(6) Windows:

(a) Located in areas accessible to residents are designed to limit the opportunities for breakage;

(b) All glazing, both interior and exterior, and glass mirrors are fabricated with laminated safety glass or equal;

(c) Use of tempered glass for interior windows is permitted.

(d) Break-away window coverings for visual privacy; and

(e) The anchorage of windows and window assemblies, including frames, is designed to resist impact loads applied from the inside and must be tested in accordance with ANSI Z97.1. Where operable windows are used, the hinges and locking devices must also be tested.

(7) Bathroom hardware and accessories

(a) Special design considerations for injury and suicide prevention must be given to shower, bath, toilet, and sink hardware and accessories, including grab bars and toilet paper holders.

(b) Grab bars:

(i) Where grab bars are provided in resident rooms, resident toilet rooms, resident bathing rooms or other non-public space, the space between the bar and the wall must be filled to prevent the grab bar from becoming a ligature point.

(8) An overall design for anti-ligature including, but not limited to, grab bars, towel hooks, levers, handles, sprinkler heads, and other protrusions.

(9) Towel bars and shower curtain rods are not permitted.

(10) In unsupervised resident areas, sprinkler heads must be recessed or of a design to minimize resident access.

(11) In resident bathrooms, lighting fixtures, sprinkler heads, electrical outlets, and other fixtures must be the tamper-resistant type.

NEW SECTION

WAC 388-107-0950 Safety—Handrails. The facility must:

(1) Provide handrails on each side of all corridors and stairwells accessible to residents and ensure that:

(a) Ends of handrails are returned to the walls;

(b) Handrails are mounted thirty to thirty-four inches above the floor; and

(c) Handrails terminate not more than six inches from a door.

(2) Equip stairways with more than one riser and ramps with slopes greater than one in twenty with handrails on both sides. Ensure that ends of handrails are designed in a manner that eliminates a hooking hazard.

NEW SECTION

WAC 388-107-0960 Plumbing—Water supply. The facility must:

(1) Provide:

(a) Water meeting the provisions of chapter 246-290 WAC, Group A public water supplies or chapter 246-291 WAC, Group B public water systems;

(b) Hot and cold water under adequate pressure readily available throughout the enhanced services facility;

(c) Labels or color codes for nonpotable water supplies as "unsafe for domestic use."

(2) Provide faucet controls in lavatories and sinks with:

(a) Either anti-ligature fixtures or fixtures with at least four-inch wrist blades or single-levers based on a risk assessment made by the facility;

(b) Sufficient space for full open and closed operation; and

(c) Color-coding and labels to indicate "hot" and "cold".

(3) Ensure that all lavatories and sinks have gooseneck spouts, without aerators in areas requiring infection control. Locations determined by the facility's risk assessment must be permitted to have anti-ligature devices.

(4) Provide shower heads that are of the flash-mounted type.

NEW SECTION

WAC 388-107-0970 Sinks—Water temperature. The facility must provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between one hundred five degrees (105°) Fahrenheit and one hundred twenty degrees (120°) Fahrenheit at all times.

NEW SECTION

WAC 388-107-0980 Mechanical—Heating systems. The facility must ensure:

(1) The heating system is capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents and seventy degrees Fahrenheit for non-resident areas.

(2) Resident rooms must have individual temperature control which may be covered, locked, or placed in an inconspicuous place.

(3) Electric resistant wall heat units are prohibited.

(4) The heating system must be connected to an alternate source of power, or an alternate source of heating must be provided to maintain the temperature in resident rooms or in a room to which all residents can be moved.

NEW SECTION

WAC 388-107-0990 Mechanical—Cooling systems. The facility must have:

(1) A mechanical cooling system capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents; and

(2) A cooling system that has mechanical refrigeration equipment to provide summer air conditioning to resident areas, food preparation areas, laundry, medication rooms, and therapy areas by either a central system with distribution ducts or piping, or packaged room or zonal air conditioners.

NEW SECTION

WAC 388-107-1000 Mechanical—Ventilation systems. The facility must ensure:

(1) Ventilation of all rooms is designed to prevent objectionable odors, condensation, and direct drafts on the residents;

(2) All habitable space is mechanically ventilated including air supply and air exhaust systems;

(3) Installation of air-handling duct systems according to the requirements of the International Mechanical Code and chapter 51-52 WAC;

(4) Installation of supply registers and return air grilles at least three inches above the floor;

(5) Installation of exhaust grilles on or near the ceiling; and

(6) Outdoor air intakes located a minimum of twenty-five feet from the exhaust from any ventilating system, combustion equipment, or areas which may collect vehicular exhaust and other noxious fumes, and a minimum of ten feet from plumbing vents. The facility must locate the bottom of outdoor air intakes serving central systems a minimum of three feet above the adjoining grade level or, if installed through the roof, three feet above the highest adjoining roof level.

(7) Minimum ventilation requirements meet the pressure relationship and ventilation rates per the following table:

PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS				
Function Area	Pressure Relationship To Adjacent Areas[1,2]	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors
RESIDENT CARE				
Resident room (holding room)	±			
Resident corridor	±			
Toilet room	N			
Resident gathering (dining, activity)	±	2	4	Optional
DIAGNOSTIC AND TREATMENT		Optional	2	Optional
Examination room	±	Optional	10	Yes
Physical therapy[3]	N	2	4	Optional
Occupational therapy[3]	N			
Soiled workroom or soiled holding	N	2	6	Optional
Clean workroom or clean holding	P	2	6	Optional
STERILIZING AND SUPPLY		2	6	Optional
Sterilizer exhaust room	N	2	10	Yes
Linen and trash chute room	N	2	4	Optional
Laundry, general[3]	±			
Soiled linen sorting and storage	N	Optional	10	Yes
Clean linen storage	P	Optional	10	Yes
SERVICE		2	10	Yes
Food preparation center[3]	±	Optional	10	Yes
Warewashing room[3]	N	Optional	2	Yes
Dietary day storage	±			
Janitor closet	N	2	10	Yes
Bathroom	N	Optional	10	Yes
Personal services (barber/salon)	N	Optional	2	Yes

[1/]P=Positive N=Negative ± = Continuous directional control not required.

[2/]Whether positive or negative, pressure must be a minimum of seventy cubic feet per minute (CFM).

[3/]The volume of air may be reduced up to fifty percent in these areas during periods of nonuse. The soiled holding area of the general laundry must maintain its full ventilation capacity at all times.

Communication

NEW SECTION

WAC 388-107-1001 Call systems on resident care units. The facility must provide a system that meets the following standards:

(1) A wired or wireless communication system that notifies at the staff work station. The system must be equipped to receive resident calls from:

(a) The bedside of each resident;

(b) Every common area, dining and activity areas, common use toilet rooms, and other areas used by residents; and

(c) Resident toilet, bath and shower rooms.

(2) The call system may be adapted to meet the resident needs.

(3) The call system may not utilize any cords.

(4) Provisions must be made for easy removal or covering of call buttons.

(5) All hardware must have tamper-resistant fasteners.

NEW SECTION

WAC 388-107-1010 Telephone on resident care units. The facility must provide twenty-four hour access to a telephone for resident use which:

(1) Provides auditory privacy;

(2) Is accessible to a resident with a disability and accommodates a resident with sensory impairment;

(3) Is not located in a staff office or at a nurse's station;

(4) Does not require payment for local calls; and

(5) Does not utilize any cords.

Electrical - Special Provisions

NEW SECTION

WAC 388-107-1020 General. In areas accessed by residents, the facility must have:

(1) Electrical receptacles that are tamper-resistant or equipped with ground fault circuit interrupters.

(2) Lights designed to prevent unauthorized access and tampering.

NEW SECTION

WAC 388-107-1030 Backup power. (1) The facility must have an alternate source of power and automatic transfer equipment to connect the alternate source within ten seconds of the failure of the normal source.

(2) The facility must ensure the alternate source is a generator:

(a) With on-site fuel supply;

(b) That is permanently fixed in place;

(3) The facility must ensure the backup power supply is coordinated with the facility's emergency plan. The system must provide a minimum of four hours of effective power for lighting for night lights, exit corridors, stairways, dining and recreation areas, work stations, medication preparation areas and boiler rooms.

(4) A facility must have alternate power supplied to:

(a) Communication systems and all alarm systems; and

(b) Electrical outlets located in medication preparation areas, pharmacy dispensing areas, staff work stations, dining areas, and resident corridors.

(5) The alternate power equipment must meet the:

(a) Earthquake standards for the facility's geographic locale; and

(b) Requirements in NFPA 110, Generators; and

(c) Requirements in NFPA 99.

Licensing

NEW SECTION

WAC 388-107-1040 License and contract. An enhanced services facility must:

(1) Be licensed by the department; and

(2) Be granted a contract by the department; and

(3) Admit and keep only those residents whose care is paid for under a department contract.

License Required/Unlicensed Operator

NEW SECTION

WAC 388-107-1050 Unlicensed operation—Application of consumer protection act. Operation of a facility without a license in violation of this chapter and discrimination against medicaid recipients is a matter vitally affecting the public interest for the purpose of applying the consumer protection act, chapter 19.86 RCW. Operation of an enhanced services facility without a license in violation of this chapter is not reasonable in relation to the development and preservation of business. Such a violation is an unfair or deceptive act in trade or commerce and an unfair method of competition for the purpose of applying the consumer protection act, chapter 19.86 RCW.

NEW SECTION

WAC 388-107-1060 Unlicensed operation—Criminal penalty. A person operating or maintaining a facility without a license under this chapter is guilty of a misdemeanor and each day of a continuing violation after conviction must be considered a separate offense.

NEW SECTION

WAC 388-107-1070 Unlicensed operation—Injunction or other remedies. Notwithstanding the existence or use of any other remedy, the department may, in the manner provided by law, maintain an action in the name of the state for an injunction, civil penalty, or other process against a person to restrain or prevent the operation or maintenance of a facility without a license issued under this chapter.

NEW SECTION

WAC 388-107-1080 Licensing fees. The enhanced services facility must:

(1) Submit an annual per bed license fee of $1,040 based on the licensed bed capacity;

(2) Submit an additional late fee in the amount of ten dollars per day from the license renewal date until the date of mailing the fee, as evidenced by the postmark; and

(3) Submit to construction review services a fee for the review of the construction documents per the review fee schedule.

NEW SECTION

WAC 388-107-1090 License valid and not transferable. (1) The enhanced services facility is not required to renew the license each year.

(2) The license remains valid unless:

(a) The department takes enforcement action to suspend or revoke the license per law;

(b) The facility voluntarily surrenders the license and closes the facility;

(c) The facility relinquishes the license; or

(d) The facility fails to pay the annual licensing fee.

(3) The facility license is:

(a) Not transferable; and

(b) Valid only for the provider and address listed on the license.

NEW SECTION

WAC 388-107-1100 Licensee's responsibilities. (1) The enhanced services facility licensee is responsible for:

(a) The operation of the enhanced services facility;

(b) Complying at all times with the requirements of this chapter, chapter 70.97 RCW, and other applicable laws and rules; and

(c) The care and services provided to the enhanced services facility residents.

(2) The licensee must:

(a) Maintain the occupancy level at or below the licensed resident bed capacity of the enhanced services facility;

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the enhanced services facility premises:

(i) A current enhanced services facility license, including any related conditions on the license;

(ii) The name, address and telephone number of:

(A) The department;

(B) Appropriate resident advocacy groups; and

(C) The state and local long-term care ombuds with a brief description of ombuds services.

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

(c) Ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds; and provides proof of bond or insurance to the department.

(3) The licensee must not delegate to any person responsibilities that are so extensive that the licensee is relieved of responsibility for the daily operations and provisions of services in the enhanced services facility.

(4) The licensee must act in accord with any department-approved management agreement, if the licensee has entered into a management agreement.

(5) The licensee must appoint an enhanced services facility administrator.

NEW SECTION

WAC 388-107-1110 Liability insurance required. The enhanced services facility must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-107-1120 and 388-107-1130; and

(2) Have evidence of liability insurance coverage available if requested by the department.

NEW SECTION

WAC 388-107-1120 Liability insurance required—Commercial general liability insurance or business liability insurance—Coverage. The enhanced services facility must have commercial general liability insurance or business liability insurance that includes:

(1) Coverage for the acts and omissions of any employee and volunteer;

(2) Coverage for bodily injury, property damage, and contractual liability;

(3) Coverage for premises, operations, independent contractor, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract; and

(4) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) General aggregate at two million dollars.

NEW SECTION

WAC 388-107-1130 Liability insurance required—Professional liability insurance coverage. The enhanced services facility must have professional liability insurance or error and omissions insurance if the enhanced services facility licensee has a professional license, or employs professionally licensed staff. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the enhanced services facility, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) Aggregate at two million dollars.

Initial License Application

NEW SECTION

WAC 388-107-1140 Licensee qualifications. (1) The department must consider separately and jointly as applicants each person named in the application for an enhanced services facility license.

(2) If the department finds any person unqualified according to regulations of this chapter, the department must deny, terminate, or not renew the license.

NEW SECTION

WAC 388-107-1150 Application process. (1) To apply for an enhanced services facility license, a person must:

(a) Submit to the department a complete license application on forms designated by the department at least sixty days prior to the proposed effective date of the license;

(b) Submit all relevant attachments specified in the application;

(c) Submit department background authorization forms;

(d) Sign the application;

(e) Submit the application fee;

(f) Submit verification that construction plans have been approved by construction review services and the state fire marshal;

(g) Submit a revised application before the license is issued if any information has changed since the initial license application was submitted;

(h) Submit a revised application containing current information about the proposed licensee or any other persons named in the application, if a license application is pending for more than one year; and

(i) If the licensee's agent prepares an application on the licensee's behalf, the licensee must review, sign and attest to the accuracy of the information contained in the application.

(2) A currently licensed facility converting to an enhanced services facility must:

(a) Give up its current license before applying; and

(b) Meet all requirements in subsection (1) above.

(3) A currently licensed facility converting a wing, or portion of the facility, to an enhanced services facility must:

(a) Change the current license to reflect the new facility structure and capacity of the existing facility;

(b) Apply for an enhanced services facility license and meet all requirements in subsection (1) above;

(c) Create a new business entity separate from the existing business structure of the current licensee; and

(d) Provide the department with enough information to show that the enhanced services facility will be operated independently from the currently licensed entity, with no shared services, separate indoor and outdoor space, separate staffing, and separate administrative structure.

(3) A license must be issued only to the person who applied for the license.

(4) A license may not exceed twelve months in duration and expires on a date set by the department.

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

NEW SECTION

WAC 388-107-1160 Necessary information. In making a determination whether to issue an enhanced services facility license, in addition to the information for each person named in the application, the department may review other documents and information the department deems relevant, including inspection and complaint investigation findings for each facility with which the applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the applicant has been affiliated.

NEW SECTION

WAC 388-107-1170 Department access. (1) The applicant must allow department staff to inspect the entire premises including all of the facility's rooms, buildings, grounds, and equipment and all pertinent records during the initial licensing of the facility.

(2) During inspections and complaint investigations, the enhanced services facility must give department staff access to:

(a) The entire premises;

(b) Examine all areas and articles in the facility that are used to provide care or support to residents, including the physical premises and residents' records and accounts;

(c) All records related to the residents or operation of the facility; and

(d) Interview anyone determined to have information pertinent to the inspection or investigation, including but not limited to the provider, staff, family members, individuals residing in the facility, and residents.

NEW SECTION

WAC 388-107-1180 Administrator qualifications—General. The licensee must appoint an administrator who:

(1) Is at least twenty-one years old;

(2) Has a Bachelor's degree in social sciences, social services, human services, behavioral sciences, or an allied medical field;

(3) Meets the training requirements under chapter 388-112 WAC and has specialized training in the provision of the care and services required for vulnerable adults with dementia, mental health and behavioral issues;

(4) Has at least one year of full-time experience working with vulnerable populations with complex personal care and behavioral needs;

(5) Knows and understands how to apply Washington state statutes and administrative rules related to the operation of a long-term care facility; and

(6) Is qualified to perform the administrator's responsibilities specified in WAC 388-107-1190.

NEW SECTION

WAC 388-107-1190 Administrator responsibilities. The licensee must ensure the administrator:

(1) Directs and supervises the overall twenty-four-hour-per-day operation of the enhanced services facility;

(2) Ensures residents receive the care and services identified in their individual treatment plan and assessment;

(3) Is readily accessible to meet with residents;

(4) Complies with the enhanced services facility's policies;

(5) When not available on the premises, either:

(a) Is available by telephone or electronic pager; or

(b) Designates a person approved by the licensee to act in place of the administrator. The designee must be:

(i) Qualified by experience to assume designated duties; and

(ii) Authorized to make necessary decisions and direct operations of the enhanced services facility during the administrator's absence.

NEW SECTION

WAC 388-107-1200 Notification of change in administrator The licensee must notify the department in writing within ten calendar days of the effective date of a change in the enhanced services facility administrator. The notice must include the full name and qualifications of the new administrator and the effective date of the change.

Criminal History Background Check

NEW SECTION

WAC 388-107-1205 Background checks—General. (1) Background checks conducted by the department and required in this chapter include:

(a) Washington state name and date of birth background checks; and

(b) After January 7, 2012, a national fingerprint background check in accordance with RCW 74.39A.056.

(2) Nothing in this chapter should be interpreted as requiring the employment of a person against the better judgment of the enhanced services facility. In addition to chapter 70.97 RCW, these rules are authorized by RCW 43.20A.710, RCW 43.43.830 through 43.43.842 and RCW 74.39A.051.

NEW SECTION

WAC 388-107-1210 Background checks—Who is required to have. (1) Applicants for an enhanced services facility license must have the following background checks before licensure:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

(2) The enhanced services facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012, have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

(3) The enhanced services facility must ensure that the following individuals have a Washington state name and date of birth background check:

(a) Volunteers who are not residents, and students who may have unsupervised access to residents;

(b) Staff persons who are not caregivers or administrators;

(c) Managers who do not provide direct care to residents; and

(d) Contractors other than the administrator and caregivers who may have unsupervised access to residents.

(4) Any individual who is required to have a background check must not have a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

NEW SECTION

WAC 388-107-1215 Background checks—Process—Background authorization form. Before the enhanced services facility employs, directly or by contract, an administrator, staff person or caregiver, or accepts any volunteer, or student, the home must:

(1) Require the person to complete a DSHS background authorization form;

(2) Submit to the department's background check central unit, including any additional documentation and information requested by the department.

NEW SECTION

WAC 388-107-1220 Background checks—Washington state name and date of birth background check. If the results of the Washington state name and date of birth background check indicate the person has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC, then the enhanced services facility must:

(1) Not employ, directly or by contract, a caregiver, administrator, or staff person; and

(2) Not allow a volunteer or student to have unsupervised access to residents.

NEW SECTION

WAC 388-107-1230 Background checks—National fingerprint background check. (1) Administrators and all caregivers who are hired after January 7, 2012, and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

(2) After receiving the results of the national fingerprint background check, the enhanced services facility must not employ, directly or by contract, an administrator or caregiver who has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

(3) The enhanced services facility may accept a copy of the national fingerprint background check results letter and any additional information from the department's background check central unit from an individual who previously completed a national fingerprint check through the department's background check central unit, provided the national fingerprint background check was completed after January 7, 2012.

NEW SECTION

WAC 388-107-1240 Background check—Results—Inform. (1) After receiving the results of the Washington

state name and date of birth background check, the enhanced services facility must:

(a) Inform the person of the results of the background check;

(b) Inform the person that they may request a copy of the results of the background check. If requested, a copy of the background check results must be provided within ten days of the request; and

(c) Notify the department and other appropriate licensing or certification agencies of any person resigning or terminated as a result of having a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

(2) After receiving the result letter for the national fingerprint background check, the enhanced services facility must inform the person:

(a) Of the national fingerprint background check result letter;

(b) That they may request a copy of the national fingerprint check result letter; and

(c) That any additional information requested can only be obtained from the department's background check central unit.

NEW SECTION

WAC 388-107-1250 Background checks—Washington state name and date of birth background check—Valid for two years—National fingerprint background check—Valid indefinitely. (1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The enhanced services facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

(2) A national fingerprint background check is valid for an indefinite period of time. The enhanced services facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

NEW SECTION

WAC 388-107-1260 Background checks—Employment—Conditional hire—Pending results of Washington state name and date of birth background check. The enhanced services facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the enhanced services facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

(2) Requires the person to sign a disclosure statement indicating if they have a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC;

(3) Has received three positive references for the person;

(4) Does not allow the person to have unsupervised access to any resident;

(5) Ensures direct supervision of the administrator, all caregivers, and staff persons; and

(6) Ensures that the person is competent, and receives the necessary training to perform assigned tasks and meets the training requirements under chapter 388-112 WAC.

NEW SECTION

WAC 388-107-1270 Background checks—Employment—Provisional hire—Pending results of national fingerprint background check. The enhanced services facility may provisionally employ a caregiver and an administrator hired after January 7, 2012, for one hundred twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

(2) The results of the national fingerprint background check are pending.

NEW SECTION

WAC 388-107-1280 Background check—Disclosure statement. (1) The enhanced services facility must require each administrator, caregiver, staff person, volunteer and student, prior to starting his or her duties, to make disclosures of any crimes or findings consistent with RCW 43.43.834(2). The disclosures must be in writing and signed by the person under penalty of perjury.

(2) The department may require the enhanced services facility or any administrator, caregiver, staff person, volunteer or student to complete additional disclosure statements or background authorization forms if the department has reason to believe that the individual has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

NEW SECTION

WAC 388-107-1290 Background check—Employment-disqualifying information. The enhanced services facility must not employ or allow an administrator, caregiver, or staff person, to have unsupervised access to residents, as defined in RCW 43.43.830, if the person has:

(1) A disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113

WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC.

(2) Has a court ordered permanent restraining order or order of protection, either active or expired, against the individual that was based upon abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult.

(3) Has a registered sex offender status.

(4) Has been convicted of a crime in any federal or state court, and the department determines that the conviction is equivalent to a conviction under chapter 388-113 WAC.

(5) has been convicted of a crime in any federal or state court, and the department determines that the conviction is equivalent to a conviction under WAC 388-113.

(6) Has one of the following negative actions:

(a) Is on a registry based upon a final finding of abuse, ne-glect, or financial exploitation, or abandonment of a vulnerable adult, unless the finding was made by Adult Protective Services prior to October 2003;

(b) Has a founded finding of abuse or neglect unless the finding was made by Child Protective Services prior to October 1, 1998;

(c) Has had a contract or license denied, terminated, revoked or suspended due to abuse, neglect, financial exploitation, or mistreatment of a child or vulnerable adult; or

(d) Has relinquished a license or terminated a contract because an agency was taking an action related to abuse, neglect, financial exploitation or mistreatment.

NEW SECTION

WAC 388-107-1300 Background checks—Employment—Non-disqualifying information. (1) If the background check results show that an employee or prospective employee has a disqualifying criminal conviction or pending charge for a disqualifying crime under chapter 388-113 WAC, or a negative action that is disqualifying under WAC 388-107-1290, unless the individual is eligible for an exception under chapter 388-113 WAC, then the enhanced services facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

(2) Nothing in this section should be interpreted as requiring the employment of any person against the better judgment of the enhanced services facility.

NEW SECTION

WAC 388-107-1310 Background check—Confidentiality—Use restricted—Retention. The enhanced services facility must ensure that all disclosure statements, background authorization forms, background check results and related information are:

(1) Maintained on-site in a confidential and secure manner;

(2) Used for employment purposes only;

(3) Not disclosed to anyone except to the individual, authorized state and federal employees, the Washington state patrol auditor, persons or health care facilities authorized by chapter 43.43 RCW; and

(4) Retained and available for department review during the individual's employment or association with a facility and for at least two years after termination of the employment or association.

Annual Renewal of License/Change in Bed Capacity

NEW SECTION

WAC 388-107-1320 Annual renewal. To renew an enhanced services facility license, the enhanced services facility must:

(1) Submit a completed license renewal application on forms designated by the department, at least thirty days prior to the license expiration date;

(2) Sign the application;

(3) Submit the annual license fee; and

(4) If the licensee's agent prepares a renewal application on the licensee's behalf, the licensee must review, sign and attest to the accuracy of the information contained on the renewal application.

NEW SECTION

WAC 388-107-1330 Changes in licensed bed capacity. To change the licensed bed capacity in an enhanced services facility, the enhanced services facility must:

(1) Be sixteen beds or less;

(2) Have met the applicable building requirements;

(3) Submit a completed request for approval to the department at least one week before the intended change;

(4) Submit the prorated fee for additional beds if applicable; and

(5) Post an amended license obtained from the department, indicating the new bed capacity.

Change of Licensee/Ownership

NEW SECTION

WAC 388-107-1340 Change in licensee/change of ownership—When change in licensee is required. The licensee of an enhanced services facility must change whenever the following events occur:

(1) The licensee's form of legal organization is changed (e.g., a sole proprietor forms a partnership or corporation);

(2) The licensee transfers ownership of the enhanced services facility business enterprise to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the enhanced services facility is also transferred;

(3) The licensee dissolves, consolidates or merges with another legal organization and the licensee's legal organization does not survive;

(4) If, during any continuous twenty-four-month period, fifty percent or more of the "licensed entity is transferred, whether by a single transaction or multiple transactions, to:

(a) A different person (e.g., new or former shareholders or partners); or

(b) A person that had less than a five percent ownership interest in the enhanced services facility at the time of the first transaction.

(5) Any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's control of the enhanced services facility. As used in this section, **"control"** means the possession, directly or indirectly, of the power to direct the management, operation and/or policies of the licensee or enhanced services facility, whether through ownership, voting control, by agreement, by contract or otherwise.

NEW SECTION

WAC 388-107-1350 Change in licensee/change of ownership—When change in licensee not required. The licensee is not required to change when only the following, without more, occur:

(1) The licensee contracts with a party to manage the enhanced services facility enterprise for the licensee pursuant to an agreement as specified in WAC 388-107-1630; or

(2) The real property or personal property assets of the enhanced services facility are sold or leased, or a lease of the real property or personal property assets is terminated, as long as there is not a substitution or substitution of control of the licensee or enhanced services facility.

NEW SECTION

WAC 388-107-1360 Change in licensee/change of ownership—Application. (1) The prospective licensee must complete, sign and submit to the department a change of ownership application prior to the proposed date of change in licensee.

(2) The annual enhanced services facility license fee, if a license fee is due, must accompany the change in ownership application.

(3) The prospective licensee must submit, along with the change of ownership application, the following information:

(a) Evidence of control of the real estate on which the enhanced services facility is located, such as a purchase and sales agreement, lease contract, or other appropriate document; and

(b) Any other information requested by the department.

(4) The prospective licensee must submit the completed application to the department within the applicable timeframes of WAC 388-107-1400 or 388-107-1410.

NEW SECTION

WAC 388-107-1370 Change in licensee/change of ownership—Revised application. The prospective licensee must submit a revised application to the department if:

(1) Any information included on the original application is no longer accurate; or

(2) Requested by the department.

NEW SECTION

WAC 388-107-1380 Change in licensee/change of ownership—Notice to department and residents. (1) In order to change the licensee of an enhanced services facility, the current licensee must notify the following in writing of the proposed change in licensee:

(a) The department; and

(b) All residents, or resident representatives (if any).

(2) The licensee must include the following information in the written notice:

(a) Name of the present licensee and prospective licensee;

(b) Name and address of the enhanced services facility for which the licensee is being changed; and

(c) Date of proposed change.

NEW SECTION

WAC 388-107-1390 Change in licensee/change of ownership—Relinquishment of license. (1) On the effective date of the change in licensee, the current enhanced services facility licensee is required to relinquish their enhanced services facility license.

(2) To relinquish a license, the licensee must mail to the department the enhanced services facility license along with a letter, addressed to the department, stating licensee's intent to relinquish the enhanced services facility license to the department.

NEW SECTION

WAC 388-107-1400 Change in licensee/change of ownership—Ninety days' notice. The current enhanced services facility licensee must provide written notice to the department and residents, or resident representatives (if any), ninety calendar days prior to the date of the change of licensee, if the proposed change of enhanced services facility licensee is anticipated to result in the discharge or transfer of any resident.

NEW SECTION

WAC 388-107-1410 Change in licensee/change of ownership—Sixty days' notice. The current enhanced services facility licensee must provide written notice to the department and residents, or resident representatives (if any), at least sixty calendar days prior to the date of the change of licensee, if the proposed change of enhanced services facility licensee is not anticipated to result in the discharge or transfer of any resident.

NEW SECTION

WAC 388-107-1420 Inspections. (1) The department must make at least one inspection of each facility prior to licensure and an unannounced full inspection of facilities at least once every eighteen months. The statewide average interval between full facility inspections must be fifteen months.

(2) Any duly authorized officer, employee, or agent of the department may enter and inspect any facility at any time to determine that the facility is in compliance with this chapter and applicable rules, and to enforce any provision of this chapter. Complaint inspections must be unannounced and

conducted in such a manner as to ensure maximum effectiveness. No advance notice must be given of any inspection unless authorized or required by federal law.

(3) During inspections, the facility must give the department access to areas, materials, and equipment used to provide care or support to residents, including resident and staff records, accounts, and the physical premises, including the buildings, grounds, and equipment. The department has the authority to privately interview the provider, staff, residents, and other individuals familiar with resident care and treatment.

(4) Any public employee giving advance notice of an inspection in violation of this section must be suspended from all duties without pay for a period of not less than five nor more than fifteen days.

(5) The department must prepare a written report describing the violations found during an inspection, and must provide a copy of the inspection report to the facility.

(6) The facility must develop a written plan of correction for any violations identified by the department and provide a plan of correction to the department within ten working days from the receipt of the inspection report.

NEW SECTION

WAC 388-107-1430 Enforcement authority—Penalties and sanctions. (1) In any case in which the department finds that a licensee of a facility, or any partner, officer, director, owner of five percent or more of the assets of the facility, or managing employee failed or refused to comply with the requirements of this chapter or the rules established under them, the department may take any or all of the following actions:

(a) Suspend, revoke, or refuse to issue or renew a license;

(b) Order stop placement; or

(c) Assess civil monetary penalties.

(2) The department may suspend, revoke, or refuse to renew a license, assess civil monetary penalties, or both, in any case in which it finds that the licensee of a facility, or any partner, officer, director, owner of five percent or more of the assets of the facility, or managing employee:

(a) Operated a facility without a license or under a revoked or suspended license;

(b) Knowingly or with reason to know made a false statement of a material fact in the license application or any data attached thereto, or in any matter under investigation by the department;

(c) Refused to allow representatives or agents of the department to inspect all books, records, and files required to be maintained or any portion of the premises of the facility;

(d) Willfully prevented, interfered with, or attempted to impede in any way the work of any duly authorized representative of the department and the lawful enforcement of any provision of this chapter;

(e) Willfully prevented or interfered with any representative of the department in the preservation of evidence of any violation of any of the provisions of this chapter or of the rules adopted under it; or

(f) Failed to pay any civil monetary penalty assessed by the department under this chapter within ten days after the assessment becomes final.

(3)(a) Civil penalties collected under this chapter must be deposited into a special fund administered by the department.

(b) Civil monetary penalties, if imposed, may be assessed and collected, with interest, for each day the facility is or was out of compliance. Civil monetary penalties must not exceed three thousand dollars per day. Each day upon which the same or a substantially similar action occurs is a separate violation subject to the assessment of a separate penalty.

(4) The department may use the civil penalty monetary fund for the protection of the health or property of residents of facilities found to be deficient including:

(a) Payment for the cost of relocation of residents to other facilities;

(b) Payment to maintain operation of a facility pending correction of deficiencies or closure; and

(c) Reimbursement of a resident for personal funds or property loss.

(5)(a) The department may issue a stop placement order on a facility, effective upon oral or written notice, when the department determines:

(i) The facility no longer substantially meets the requirements of this chapter; and

(ii) The deficiency or deficiencies in the facility:

(A) Jeopardizes the health and safety of the residents; or

(B) Seriously limits the facility's capacity to provide adequate care.

(b) When the department has ordered a stop placement, the department may approve a readmission to the facility from a hospital, residential treatment facility, or crisis intervention facility when the department determines the readmission would be in the best interest of the individual seeking readmission.

(6) If the department determines that an emergency exists and resident health and safety is immediately jeopardized as a result of a facility's failure or refusal to comply with this chapter, the department may summarily suspend the facility's license and order the immediate closure of the facility, or the immediate transfer of residents, or both.

(7) If the department determines that the health or safety of the residents is immediately jeopardized as a result of a facility's failure or refusal to comply with requirements of this chapter, the department may appoint temporary management to:

(a) Oversee the operation of the facility; and

(b) Ensure the health and safety of the facility's residents while:

(i) Orderly closure of the facility occurs; or

(ii) The deficiencies necessitating temporary management are corrected.

NEW SECTION

WAC 388-107-1440 Enforcement orders—Hearings. (1) All orders of the department denying, suspending, or revoking the license or assessing a monetary penalty must

become final twenty days after the same has been served upon the applicant or licensee unless a hearing is requested.

(2) All orders of the department imposing stop placement, temporary management, emergency closure, emergency transfer, or summary license suspension must be effective immediately upon notice, pending any hearing.

(3) Subject to the requirements of subsection (2) of this section, all hearings under this chapter and judicial review of such determinations must be in accordance with the administrative procedure act, chapter 34.05 RCW.

Resident Protection Program

NEW SECTION

WAC 388-107-1450 Resident protection program definition. As used in WAC 388-107-1460 through 388-107-1550,the term **"individual,"** means anyone used by the enhanced services facility to provide services to residents who is alleged to have abandoned, abused, neglected, or misappropriated property of a resident or financially exploited a resident. "Individual" includes, but is not limited to, employees, contractors, and volunteers.

NEW SECTION

WAC 388-107-1460 Investigation of mandated reports. (1) The department will review all allegations of resident abandonment, abuse, neglect, or financial exploitation, or misappropriation of resident property, as those terms are defined in chapter RCW 74.34.020.

(2) If, after the review of an allegation, the department concludes that there is reason to believe that an individual has abandoned, abused, neglected, or financially exploited a resident, or has misappropriated a resident's property, then the department will initiate an investigation.

(3) The department's investigation may include, but is not limited to:

(a) The review of facility and state agency records;

(b) Interviews with anyone who may have relevant information about the allegation; and

(c) The collection of any evidence deemed necessary by the investigator.

NEW SECTION

WAC 388-107-1470 Preliminary finding. If, after review of the results of the investigation, the department determines that an individual has abandoned, abused, neglected, or financially exploited a resident, or has misappropriated a resident's property, the department will make a preliminary finding to that effect. However, a preliminary finding of neglect will not be made if the individual demonstrates that the neglect was caused by factors beyond the control of the individual.

NEW SECTION

WAC 388-107-1480 Notice to individual of preliminary findings. (1) The department will serve notice of the preliminary finding as provided in WAC 388-107-1560.

(2) The department may establish proof of service as provided in WAC 388-107-1570.

NEW SECTION

WAC 388-107-1490 Notice to others of preliminary findings. Consistent with confidentiality requirements concerning the resident, witnesses, and the reporter, the department may provide notification of a preliminary finding to:

(1) Other divisions within the department;

(2) The agency, program or employer where the incident occurred;

(3) The employer or program that is currently associated with the individual;

(4) Law enforcement;

(5) Other entities as authorized by law including chapter 74.34 RCW and this chapter; and

(6) The appropriate licensing agency.

NEW SECTION

WAC 388-107-1500 Disputing a preliminary finding. (1) The individual may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the individual's written request for an administrative hearing within thirty calendar days of the date of the notice of the preliminary finding; except under the circumstances described in subsection (4).

(4) If an individual requests a hearing within one hundred eighty days of the date of the notice of the preliminary finding and the individual can demonstrate good cause for failing to request a hearing within thirty days, the office of administrative hearings may grant the request. Under these circumstances, the finding against the individual will remain on the department's registry pending the outcome of the hearing.

NEW SECTION

WAC 388-107-1510 Hearing procedures to dispute preliminary finding. Upon receipt of a written request for a hearing from an individual, the office of administrative hearings will schedule a hearing, taking into account the following requirements:

(1) The hearing decision must be issued within one hundred twenty days of the date the office of administrative hearings receives a hearing request, except as provided in subsection (6);

(2) Neither the department nor the individual can waive the one hundred twenty day requirement;

(3) The hearing will be conducted at a reasonable time and at a place that is convenient for the individual;

(4) The hearing, and any subsequent appeals, will be governed by this chapter, chapter 34.05 RCW, and chapter 388-02 WAC, or its successor regulations;

(5) A continuance may be granted for good cause upon the request of any party, as long as the hearing decision can still be issued within one hundred twenty days of the date of

the receipt of the appeal, except under the circumstances described in subsection 6;

(6) If the administrative law judge finds that extenuating circumstances exist that will make it impossible to render a decision within one hundred twenty days, the administrative law judge may extend the one hundred twenty day requirement by a maximum of sixty days; and

(7) To comply with the time limits described in this section, the individual must be available for the hearing and other preliminary matters. If the decision is not rendered within the time limit described in subsection (1), or if appropriate under subsection (6), the administrative law judge must issue an order dismissing the appeal and the preliminary finding will become final.

NEW SECTION

WAC 388-107-1520 Finalizing the preliminary finding. (1) The preliminary finding becomes a final finding when:

(a) The department notifies the individual of a preliminary finding and the individual does not ask for an administrative hearing within the time frame provided under WAC 388-107-1510;

(b) The individual requested an administrative hearing to appeal the preliminary finding and the administrative law judge:

(i) Dismisses the appeal following withdrawal of the appeal or default;

(ii) Dismisses the appeal for failure to comply with the time limits under WAC 388-107-1510; or

(iii) Issues an initial order upholding the finding; or

(c) The board of appeals reverses an administrative law judge's initial order and issues a final order upholding the preliminary finding.

(2) A final finding is permanent, except under the circumstances described in (3).

(3) A final finding may be removed from the department's registry and, as appropriate, any other department lists under the following circumstances:

(a) The department determines the finding was made in error;

(b) The finding is rescinded following judicial review; or

(c) The department is notified of the individual's death.

NEW SECTION

WAC 388-107-1530 Reporting final findings. The department will report a final finding of abandonment, abuse, neglect, financial exploitation of a resident, and misappropriation of resident property within ten working days to the following:

(1) The individual;

(2) The current administrator of the facility in which the incident occurred;

(3) The administrator of the facility that currently employs the individual, if known;

(4) The department's registry;

(5) The appropriate licensing authority; and

(6) Any other lists maintained by a state or federal agency as appropriate.

NEW SECTION

WAC 388-107-1540 Appeal of administrative law judge's initial order or finding. (1) If the individual or the department disagrees with the administrative law judge's decision, either party may appeal this decision by filing a petition for review with the department's board of appeals as provided under chapter 34.05 RCW and chapter 388-02 WAC.

(2) If the individual appeals the administrative law judge's decision, the finding will remain on the department's registry or other lists.

NEW SECTION

WAC 388-107-1550 Disclosure of investigative and finding information. (1) Information obtained during the investigation into allegations of abandonment, abuse, neglect, misappropriation of property, or financial exploitation of a resident, and any documents generated by the department will be maintained and disseminated with regard for the privacy of the resident and any reporting individuals and in accordance with laws and regulations regarding confidentiality and privacy.

(2) Confidential information about residents and mandated reporters provided to the individual by the department must be kept confidential and may only be used by the individual to challenge findings through the appeals process.

(3) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the residents will be redacted from the documents unless release of that information is consistent with chapter 74.34 RCW and other applicable state and federal laws.

General Notice Requirements

NEW SECTION

WAC 388-107-1560 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the individual or facility at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; or

(5) Notice is delivered to a legal messenger service with charges prepaid.

NEW SECTION

WAC 388-107-1570 Notice—Proof of service. The department may establish proof of service by any of the following:

(1) A declaration of personal service;

(2) An affidavit or certificate of mailing to the enhanced services facility or to the individual to whom notice is directed;

(3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; or

(4) Proof of fax transmission.

Policies

NEW SECTION

WAC 388-107-1580 Policies and procedures. (1) The enhanced services facility must develop and implement written policies and procedures for all treatment, care and services provided in the facility.

(2) The enhanced services facility must train staff persons on implementation of all the policies and procedures.

(3) The facility must ensure that the policies and procedures include, at a minimum the following:

(a) Transitioning new residents;

(b) Security precautions to meet the safety needs of the residents;

(c) Delayed egress, when used by the facility;

(d) Crisis prevention and response protocol;

(e) Discharge planning;

(f) Compliance with resident rights, consistent with WAC 388-107-0190;

(g) Suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(h) Situations in which there is reason to believe a resident is not capable of making necessary decisions and no substitute decision maker is available;

(i) Situations in which a substitute decision maker is no longer appropriate;

(j) Situations in which a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

(k) Response to medical emergencies;

(l) Urgent situations in the enhanced services facility requiring additional staff support;

(m) Appropriate responses to residents engaging in aggressive or assaultive behavior, including, but not limited to:

(i) Preventive actions for a behavioral crisis or violent behavior;

(ii) Actions to take to protect other residents;

(iii) When and how to seek outside intervention;

(iv) Training on de-escalation techniques for managing resident's challenging behavior before it reaches the stage of physical aggression or assault;

(v) Techniques for staff to use in response to aggressive behaviors when de-escalation techniques have not succeeded;

(vi) Evaluation of the safety of the physical environment;

(vii) Issues of respect and dignity of the client; and

(viii) Use of the least restrictive physical and behavioral interventions depending upon the situation, including use of holding techniques to physically restrain residents.

(n) Preventing and limiting the spread of infections, including tuberculosis, consistent with WACs 388-107-0440;

(o) Providing sub-acute detoxification services approved by an authorized health care provider and ensuring resident health and safety;

(p) Prohibition of restraints, except when necessary to ensure the safety of residents and others;

(q) Use of drugs, including marijuana, for staff or residents; and

(r) Presence of firearms in the facility, including provisions for keeping firearms locked and accessible only to authorized persons.

(4) The enhanced services facility must make the policies and procedures specified in subsection (3) of this section available to staff persons at all times and must inform residents and residents' representatives of their availability and make them available upon request.

NEW SECTION

WAC 388-107-1590 Emergency response teams. (1) The enhanced services facility must have a plan in place to address emergency responses to behavioral crisis in order to protect the residents and staff.

(2) The enhanced services facility must develop a policy of emergency response notification, including after-hours notification. Subjects of notification may include:

(a) Law enforcement;

(b) Chemical dependency or mental health professional;

(c) Emergency medical personnel;

(d) Program administrator and supervisor;

(e) Resident's case manager; and

(f) Facility treatment team.

NEW SECTION

WAC 388-107-1600 Emergency disaster plan. (1) The enhanced services facility must develop and implement detailed written plans and procedures to meet potential emergencies and disasters. At a minimum, the enhanced services facility must ensure these plans provide for:

(a) Fire or smoke;

(b) Severe weather;

(c) Loss of power;

(d) Earthquake;

(e) Explosion;

(f) Missing resident, elopement;

(g) Loss of normal water supply;

(h) Bomb threats;

(i) Armed individuals;

(j) Gas leak, or loss of service; and

(k) Loss of heat supply.

(2) The enhanced services facility must train all employees in emergency procedures when they begin work in the enhanced services facility, periodically review emergency procedures with existing staff, and carry out unannounced staff drills using those procedures.

(3) The enhanced services facility must ensure emergency plans:

(a) Are developed and maintained with the assistance of qualified fire, safety, and other appropriate experts as necessary;

(b) Are reviewed annually;

(c) Include plans to continue to serve and meet the needs of the residents during the emergency; and

(d) Include evacuation routes prominently posted on each unit.

NEW SECTION

WAC 388-107-1610 Pets. (1) Each resident must have a reasonable opportunity to have regular contact with animals, if desired.

(2) The enhanced services facility must:

(a) Consider the recommendations of enhanced services facility residents and staff;

(b) Determine how to provide residents access to animals;

(c) Determine the type and number of animals available in the facility, which the facility can safely manage. Such animals should include only those customarily considered domestic pets;

(d) Ensure that any resident's rights, preferences, and medical needs are not compromised by the presence of an animal; and

(e) Ensure any animal visiting or living on the premises has a suitable temperament, is healthy, and otherwise poses no significant health or safety risks to residents, staff, or visitors.

(3) Animals living on the enhanced services facility premises must:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state; and

(b) Be veterinarian certified to be free of diseases transmittable to humans.

(4) Pets must be restricted from:

(a) Central food preparation areas; and

(b) Residents who object to the presence of pets.

NEW SECTION

WAC 388-107-1620 Management agreements/subcontracting staff. (1) If the proposed or current licensee uses a manager, the licensee must have a written management agreement approved by the department that is consistent with this chapter.

(2) The proposed or current licensee must notify the department of its use of a manager upon:

(a) Initial application for a license;

(b) Retention of a manager following initial application;

(c) Change of managers; and

(d) Modification of existing management agreement.

(3) The proposed or current licensee must provide a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations.

(4) The written management agreement must be submitted:

(a) Sixty days before:

(i) The initial licensure date;

(ii) The proposed change of ownership date; or

(iii) The effective date of the management agreement; or

(b) Thirty days before the effective date of any amendment to an existing management agreement.

(5) The proposed licensee or the current licensee must notify the residents and their representatives sixty days before entering into a management agreement.

NEW SECTION

WAC 388-107-1630 Management agreements—Licensee. (1) The licensee is responsible for:

(a) The daily operations and provisions of services in the enhanced services facility;

(b) Ensuring the enhanced services facility is operated in a manner consistent with all laws and rules applicable to enhanced services facilities;

(c) Ensuring the manager acts in conformance with a department approved management agreement; and

(d) Ensuring the manager does not represent itself as, or give the appearance that it is the licensee.

(2) The licensee must not give the manager responsibilities that are so extensive that the licensee is relieved of daily responsibility for the daily operations and provision of services in the enhanced services facility. If the licensee does so, then the department must determine that a change of ownership has occurred.

(3) The licensee and manager must act in accordance with the terms of the department-approved management agreements. If the department determines they are not, then the department may take licensing action.

(4) The licensee may enter into a management agreement only if the management agreement creates a principal/agent relationship between the licensee and manager.

NEW SECTION

WAC 388-107-1640 Management agreements—Terms of agreement. Management agreements, at a minimum must:

(1) Describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(2) Require the licensee's governing body, board of directors, or similar authority to appoint the facility administrator;

(3) Provide for the maintenance and retention of all records in accordance with this chapter and other applicable laws;

(4) Allow unlimited access by the department to documentation and records according to applicable laws or regulations;

(5) Require the manager to immediately send copies of inspections and notices of noncompliance to the licensee;

(6) State that the licensee is responsible for reviewing, acknowledging and signing all enhanced services facility initial and renewal license applications;

(7) State that the manager and licensee will review the management agreement annually and notify the department of any change according to applicable regulations;

(8) Acknowledge that the licensee is the party responsible for complying with all laws and rules applicable to enhanced services facilities;

(9) Require the licensee to maintain ultimate responsibility over personnel issues relating to the operation of the enhanced services facility and care of the residents, including but not limited to, staffing plans, orientation and training;

(10) State the manager will not represent itself, or give the appearance it is the licensee; and

(11) State that a duly authorized manager may execute resident agreements on behalf of the licensee, but all such resident agreements must be between the licensee and the resident.

NEW SECTION

WAC 388-107-1650 Management agreements—Department review. Upon receipt of a proposed management agreement, the department may require:

(1) The proposed or current licensee or manager to provide additional information or clarification;

(2) Any changes necessary to:

(a) Bring the management agreement into compliance with this chapter; and

(b) Ensure that the licensee has not been relieved of the responsibility for the daily operations of the facility.

(3) The licensee to participate in monthly meetings and quarterly on-site visits to the enhanced services facility.

NEW SECTION

WAC 388-107-1660 Management agreements—Resident funds. (1) If the management agreement delegates day-to-day management of resident funds to the manager, the licensee:

(a) Retains all fiduciary and custodial responsibility for funds that have been deposited with the enhanced services facility by the resident;

(b) Is directly accountable to the residents for such funds; and

(c) Must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds; and provides proof of bond or insurance.

(2) If responsibilities for the day-to-day management of the resident funds are delegated to the manager, the manager must:

(a) Provide the licensee with a monthly accounting of the resident funds; and

(b) Meet all legal requirements related to holding, and accounting for, resident funds.

WSR 14-04-004
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed January 22, 2014, 3:57 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-24-061.

Title of Rule and Other Identifying Information: WAC 392-343-035(3) Space allocations.

Hearing Location(s): Office of Superintendent of Public Instruction (OSPI), Old Capitol Building, Wanamaker, P.O. Box 47200, Olympia, WA 98504-7200, on March 18, 2014, at 10:00 a.m.

Date of Intended Adoption: March 18, 2014.

Submit Written Comments to: Scott Black, OSPI, Old Capitol Building, P.O. Box 47200, 600 Washington Street S.E., Olympia, WA 98504-7200, e-mail Scott.black@k12.wa.us, fax (360) 586-3946.

Assistance for Persons with Disabilities: Contact Wanda Griffin by March 15, 2014, TTY (360) 664-3631 or (360) 725-6132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: In accordance with the proviso language in ESSB 5035, the small high school space allocation calculation changed from 0-100 student headcount to 0-200 student headcount.

Statutory Authority for Adoption: RCW 28A.150.290.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: [OSPI], governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Scott Black, P.O. Box 47200, Olympia, WA 98504-7200, (360) 725-6268; and Enforcement: Gordon Beck, P.O. Box 47200, Olympia, WA 98504-7200, (360) 725-6265.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

January 22, 2014
Randy Dorn
State Superintendent
of Public Instruction

AMENDATORY SECTION (Amending WSR 10-09-008, filed 4/8/10, effective 5/9/10)

WAC 392-343-035 Space allocations. (1) State funding assistance in the construction of school facilities for grades kindergarten through twelve and classrooms planned for the exclusive use of students with developmental disabilities shall be based on a space allocation per enrolled student and for state funding assistance purposes shall be computed in accordance with the following table:

Grade or Area	Through June 30, 2006 Maximum Space Allocation Per Student	Beginning July 1, 2006 Maximum Space Allocation Per Student
Grades kindergarten through six	80 square feet	90 square feet
Grades seven and eight	110 square feet	117 square feet

Grade or Area	Through June 30, 2006 Maximum Space Allocation Per Student	Beginning July 1, 2006 Maximum Space Allocation Per Student
Grades nine through twelve	120 square feet	130 square feet
Classrooms for students with developmental disabilities	140 square feet	144 square feet

For purposes of this subsection, students with developmental disabilities shall be counted as one student for each such student assigned to a specially designated self-contained classroom for students with developmental disabilities for at least one hundred minutes per school day, calculated on actual headcount enrollment submitted to the superintendent of public instruction.

(2) State funding assistance for construction of vocational skill centers shall be based on one-half of students enrolled on October 1 and computed as follows:

Type of Facility	Maximum Space Allocation Per One-Half Enrolled Student
Skill Centers	140 square feet

(3) Space allocation for state funding assistance purposes for districts with senior or four-year high schools with fewer than four hundred students shall be computed in accordance with the following formula:

Number of Headcount Student-Grades 9-12	Maximum Space Allocation Per Facility
((~~0-100~~	~~37,000 square feet~~))
((~~101~~)) 01-200	42,000 square feet
201-300	48,000 square feet
301-or more	52,000 square feet

WSR 14-04-005
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION
[Filed January 22, 2014, 3:59 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-24-062.

Title of Rule and Other Identifying Information: WAC 392-340-210 Adjustment of assets and liabilities—Time considerations.

Hearing Location(s): Office of Superintendent of Public Instruction (OSPI), Old Capitol Building, Wanamaker, P.O. Box 47200, Olympia, WA 98504-7200, on March 18, 2014, at 10:30 a.m.

Date of Intended Adoption: March 18, 2014.

Submit Written Comments to: Scott Black, OSPI, Old Capitol Building, P.O. Box 47200, 600 Washington Street S.E., Olympia, WA 98504-7200, e-mail Scott.black@k12.wa.us, fax (360) 586-3946.

Assistance for Persons with Disabilities: Contact Wanda Griffin by March 15, 2014, TTY (360) 664-3631 or (360) 725-6132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Changes to WAC 392-340-210 are necessary to be consistent with county deadline for establishing taxing rates in the event of a school district boundary change. The deadline for establishing taxing rates for the following year is August 1.

Statutory Authority for Adoption: RCW 28A.150.290.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: [OSPI], governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Scott Black, P.O. Box 47200, Olympia, WA 98504-7200, (360) 725-6268; and Enforcement: Gordon Beck, P.O. Box 47200, Olympia, WA 98504-7200, (360) 725-6265.

No small business economic impact statement has been prepared under chapter 19.85 RCW.

A cost-benefit analysis is not required under RCW 34.05.328.

January 22, 2014
Randy Dorn
State Superintendent
of Public Instruction

AMENDATORY SECTION (Amending WSR 09-03-053, filed 1/13/09, effective 2/13/09)

WAC 392-340-210 Adjustment of assets and liabilities—Time considerations. A regional committee is authorized to phase in the adjustment of assets and liabilities over a period not less than two years nor more than eight years. This authorization is subject to the annual ((~~March~~)) August 1 deadline for taxing districts to establish the taxing boundaries and rates for the ensuing tax collection year.

WSR 14-04-022
PROPOSED RULES
DEPARTMENT OF HEALTH
(Dental Quality Assurance Commission)
[Filed January 27, 2014, 8:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 09-13-097.

Title of Rule and Other Identifying Information: WAC 246-817-305 Record content and 246-817-310 Record retention and accessibility requirements, creating a new rule and amending an existing rule to provide dental treatment record content and retention requirements.

Hearing Location(s): Department of Health, 310 Israel Road S.E., Room 152/153, Tumwater, WA 98501, on April 18, 2014, at 8:00 a.m.

Date of Intended Adoption: April 18, 2014.

Submit Written Comments to: Jennifer Santiago, P.O. Box 47852, Olympia, WA 98504-7852, e-mail http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by April 11, 2014.

Assistance for Persons with Disabilities: Contact Jennifer Santiago by April 11, 2014, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules modify WAC 246-817-310 and creates new WAC 246-817-305. The proposed rules provide detailed requirements for content that must be included in a patient record. The proposed rules also remove unnecessary and outdated language.

Reasons Supporting Proposal: The proposed rules clarify what should be included in a patient record. The proposed rules also ensure that patient records are complete, legible, and consistent. A complete and accurate patient record is vital for patient safety and for appropriate regulation. Thorough records are necessary to inform the work of other treatment providers who subsequently treat the patient, as well as for the commission when investigating complaints and regulating practitioners.

Statutory Authority for Adoption: RCW 18.32.655 and 18.32.0365.

Statute Being Implemented: RCW 18.32.655 and 18.32.-0365.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state dental quality assurance commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Jennifer Santiago, 310 Israel Road S.E., Tumwater, WA 98501, (360) 236-4893.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is required under RCW 34.05.-328. A preliminary cost-benefit analysis may be obtained by contacting Jennifer Santiago, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-4893, fax (360) 236-2901, e-mail jennifer.santiago@doh.wa.gov.

January 24, 2014
LouAnn Mercier, D.D.S.
Chair

NEW SECTION

WAC 246-817-305 Record content. (1) A licensed dentist who treats patients shall maintain legible, complete, and accurate patient records.

(2) The patient record must reflect diagnosis and treatment performed and contain financial records.

(3) The patient record must include at least the following information:

(a) For each record entry, the signature or electronic verification of the responsible dentist or dental hygienist;

(b) The date of each patient record entry, document, radiograph or model;

(c) An up-to-date treatment plan;

(d) The physical examination findings documented by subjective complaints, objective findings, and an assessment or diagnosis of the patient's condition;

(e) Up-to-date dental and medical history that may affect dental treatment;

(f) Any diagnostic aid used including, but not limited to, images, radiographs, and test results. Retention of molds or study models except for orthodontia or full mouth reconstruction is at the discretion of the practitioner;

(g) A complete description of all treatment/procedures administered at each visit;

(h) An accurate record of any medication(s) administered, prescribed or dispensed including:

(i) The date prescribed or the date dispensed;

(ii) The name of the patient prescribed or dispensed to;

(iii) The name of the medication; and

(iv) The dosage and amount of the medication prescribed or dispensed, including refills;

(i) Referrals and any communication to and from any health care provider;

(j) Notation of communication to or from the patient or patient's parent or guardian, including:

(i) Discussion of potential risk(s) and benefit(s) of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;

(ii) Posttreatment instructions;

(iii) Patient complaints and resolutions; and

(iv) Termination of doctor-patient relationship; and

(k) A copy of each laboratory referral retained for three years as required in RCW 18.32.655.

(4) Complete manual treatment entries must not be erased or deleted from the record.

(a) Mistaken manual entries must be corrected with a single line drawn through the incorrect information. New or corrected information must be initialed and dated.

(b) Complete electronic treatment entries must include deletions, edits, and corrections.

AMENDATORY SECTION (Amending WSR 95-21-041, filed 10/10/95, effective 11/10/95)

WAC 246-817-310 ((~~Maintenance and~~)) Record retention ((~~of records~~)) and accessibility requirements. ((~~Any dentist who treats patients in the state of Washington shall maintain complete treatment records regarding patients treated. These records shall include, but shall not be limited to X-rays, treatment plans, patient charts, patient histories, correspondence, financial data and billing. These records shall be retained by the dentist for five years in an orderly, accessible file and shall be readily available for inspection by the DQAC or its authorized representative: X-rays or copies of records may be forwarded to a second party upon the patient's or authorized agent's written request. Also, office records shall state the date on which the records were released, method forwarded and to whom, and the reason for the release. A reasonable fee may be charged the patient to cover mailing and clerical costs.~~

~~Every dentist who operates a dental office in the state of Washington must maintain a comprehensive written and dated record of all services rendered to his/her patients. In offices where more than one dentist is performing the services the records must specify the dentist who performed the services. Whenever requested to do so, by the secretary or his/her authorized representative, the dentist shall supply documentary proof:~~

~~(1) That he/she is the owner or purchaser of the dental equipment and/or the office he occupies.~~

~~(2) That he/she is the lessee of the office and/or dental equipment.~~

~~(3) That he/she is, or is not, associated with other persons in the practice of dentistry, including prosthetic dentistry, and who, if any, the associates are.~~

~~(4) That he/she operates his office during specific hours per day and days per week, stipulating such hours and days.~~)) (1) A licensed dentist who treats patients eighteen years and older shall keep readily accessible patient records for at least six years from the date of the last treatment.

(2) A licensed dentist who treats patients under the age of eighteen years old shall keep readily accessible patient records for at least six years after the patient reaches eighteen years old.

(3) A licensed dentist shall respond to a written request to examine or copy a patient's record within fifteen working days after receipt. A licensed dentist shall comply with chapter 70.02 RCW for all patient record requests.

(4) A licensed dentist shall comply with chapter 70.02 RCW and the Health Insurance Portability and Accountability Act, 45 C.F.R. destruction and privacy regulations.

WSR 14-04-062
PROPOSED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed January 28, 2014, 11:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-14-054.

Title of Rule and Other Identifying Information: Amends WAC 181-78A-535 on the requirements for completion of a professional certification program. Removes panel requirements.

Hearing Location(s): Holiday Inn, Downtown Everett, 3105 Pine Street, Everett, WA 98201, on March 13, 2014, at 8:30.

Date of Intended Adoption: March 13, 2014.

Submit Written Comments to: David Brenna, 600 Washington Street, Room 400, Olympia, WA 98504, e-mail david.brenna@k12.wa.us, fax (360) 586-4548, by March 6, 2014.

Assistance for Persons with Disabilities: Contact David Brenna by March 6, 2014, (360) 725-6238.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Clarifies the requirements of professional certification for certain classes of educators. Removes the professional panel requirement. Amends WAC 181-78A-535.

Reasons Supporting Proposal: Streamlines the requirements and increases the rigor.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: David Brenna, P.O. Box 42736 [47236], Olympia, WA 98504, (360) 725-6238.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed amendment does not have an impact on small business and therefore does not meet the requirements for a statement under RCW 19.85.030 (1) or (2).

A cost-benefit analysis is required under RCW 34.05.-328. A preliminary cost-benefit analysis may be obtained by contacting David Brenna, 600 Washington Street, Olympia, WA 98504, phone (360) 725-6238, fax (360) 586-4548, e-mail david.brenna@k12.wa.us.

January 27, 2014
David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 12-18-003, filed 8/23/12, effective 9/23/12)

WAC 181-78A-535 Approval standard—Program design. The following requirements shall govern the professional certificate program:

(1) Recruitment and admission.

(a) Programs will, at a minimum, recruit and admit any candidates in their service region who hold a residency certificate and at least two years of experience in the role.

(b) ((~~Learner~~)) Candidate expectations for program requirements, progression, and completion are identified, published, and accessible.

(2) Program design.

(a) Entry seminar.

(i) The program provides an orientation to the process and to the benchmarks/strands.

(ii) ((~~The program includes formalized learning opportunities and other activities directed at developing and verifying that the candidate has achieved acceptable knowledge, skill, and performance at the professional certificate benchmark level, or above, on all standards as defined in WAC 181-78A-270.~~

~~(iii) Administrator~~)) Candidates will ((~~complete~~)) begin a 360-type assessment aligned to the ((~~interstate school leaders licensure consortium standards~~)) professional educator standards board approved standards for the certification role, to be finalized prior to program completion.

(b) Action research project. The program includes a job-embedded, evidence-based project designed to improve student achievement, within which the candidate provides evidence of professional certificate level knowledge, skill, and performance. The project will be evaluated and scored on the basis of a common rubric appropriate for the certification role. The common rubrics shall be developed in collaboration

with programs and published by the professional educator standards board.

(((~~(b)~~))) (c) Professional performance growth ((~~plan implementation~~)) and verification.

(i) The program includes formalized learning opportunities and other activities directed at developing and verifying that the candidate has achieved acceptable knowledge, skill, and performance at the professional certification benchmark level, or above, on all standards as defined in WAC 181-78A-270.

(ii) The program includes the development of a draft professional growth plan focused on the career level standards.

(((~~(c) Panel presentation.~~

~~(i) The program includes a final presentation to a panel that includes experienced P-12 educators in the role, during which the candidate provides evidence of professional certificate level knowledge, skill, and performance.~~

~~(ii) Candidates who do not successfully complete a final presentation receive an individualized analysis of strengths and weaknesses and a plan for assistance, and shall be allowed additional opportunities to present evidence pertaining to strands/benchmarks not previously met.~~))

(3) School-based experiences.

(a) Candidate work produced in the program is responsive to, and integrated with, the job responsibilities of candidates.

(b) Entry and exit criteria and a process for mitigating concerns are provided for candidates.

(4) Collaboration. Program personnel collaborate for continuous program improvement with P-12 partners, PEAB members, and candidates.

(5) Diversity in learning experiences.

(a) Candidates reflect on interactions with diverse populations in order to integrate professional growth in cultural competency as a habit of practice.

(b) Program personnel model equity pedagogy through:

(i) Interactions with diverse populations;

(ii) Reflective practice on their own professional growth in cultural competency;

(iii) Culturally relevant communication and problem solving; and

(iv) Personalized instruction that addresses cultural and linguistic backgrounds.

WSR 14-04-063
PROPOSED RULES
LIQUOR CONTROL BOARD

[Filed January 29, 2014, 10:44 a.m.]

Supplemental Notice to WSR 13-24-125.

Preproposal statement of inquiry was filed as WSR 13-07-027.

Title of Rule and Other Identifying Information: WAC 314-55-083 What are the security requirements for a marijuana licensee? and 314-55-102 Quality assurance testing; and new sections WAC 314-55-200 How will the liquor control board identify marijuana, useable marijuana, and marijuana infused product during checks of licensed businesses?, 314-55-210 Will the liquor control board seize or confiscate marijuana, useable marijuana, and marijuana-infused products?, 314-55-220 What is the process once the board summarily orders marijuana, useable marijuana, or marijuana-infused products of a marijuana licensee to be destroyed?, and 314-55-230 What are the procedures the liquor control board will use to destroy or donate marijuana, useable marijuana, or marijuana-infused products to law enforcement?

Hearing Location(s): Washington State Liquor Control Board, Board Room, 3000 Pacific Avenue S.E., Olympia, WA 98504, on March 12, 2014, at 10:00 a.m.

Date of Intended Adoption: March 19, 2014.

Submit Written Comments to: Karen McCall, P.O. Box 43080, Olympia, WA 98504, e-mail rules@liq.wa.gov, fax (360) 66-9689 [664-9689], by March 12, 2014.

Assistance for Persons with Disabilities: Contact Karen McCall by March 12, 2014, (360) 664-1631.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Initiative 502 legalized marijuana for recreational use under certain conditions. These rules are to implement I-502 and to further clarify other permanent rules to implement I-502.

Reasons Supporting Proposal: This is a new industry in the state of Washington. Rules are needed to clarify the new laws created by I-502 so the public is aware of the qualifications and requirements for marijuana licenses in the state of Washington.

Statutory Authority for Adoption: RCW 69.50.342, 69.50.345.

Statute Being Implemented: RCW 69.50.342, 69.50.345.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state liquor control board, governmental.

Name of Agency Personnel Responsible for Drafting: Karen McCall, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1631; Implementation: Alan Rathbun, Licensing Director, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1615; and Enforcement: Justin Nordhorn, Enforcement Chief, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1726.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement was not required.

A cost-benefit analysis is not required under RCW 34.05.328.

January 29, 2014
Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-083 What are the security requirements for a marijuana licensee? The security requirements for a marijuana licensee are as follows:

(1) **Display of identification badge.** All employees on the licensed premises shall be required to hold and properly display an identification badge issued by the licensed employer at all times while on the licensed premises.

(2) **Alarm systems.** At a minimum, each licensed premises must have a security alarm system on all perimeter entry points and perimeter windows. Motion detectors, pressure switches, duress, panic, and hold-up alarms may also be utilized.

(3) **Surveillance system.** At a minimum, a complete video surveillance with minimum camera resolution of 640x470 pixel and must be internet protocol (IP) compatible and recording system for controlled areas within the licensed premises and entire perimeter fencing and gates enclosing an outdoor grow operation, to ensure control of the area. The requirements include image acquisition, video recording, management and monitoring hardware and support systems. All recorded images must clearly and accurately display the time and date. Time is to be measured in accordance with the U.S. National Institute Standards and Technology standards.

(a) All controlled access areas, security rooms/areas and all points of ingress/egress to limited access areas, all points of ingress/egress to the exterior of the licensed premises, and all point-of-sale (POS) areas must have fixed camera coverage capable of identifying activity occurring within a minimum of twenty feet of all entry and exit points.

(b) Camera placement shall allow for the clear and certain identification of any individual on the licensed premises.

(c) All entrances and exits to the facility shall be recorded from both indoor and outdoor vantage points, and capable of clearly identifying any activities occurring within the facility or within the grow rooms in low light conditions. The surveillance system storage device must be secured onsite in a lock box, cabinet, closet, or secured in another manner to protect from employee tampering or criminal theft.

(d) All perimeter fencing and gates enclosing an outdoor grow operation must have full video surveillance capable of clearly identifying any activities occurring within twenty feet of the exterior of the perimeter. Any gate or other entry point that is part of the enclosure for an outdoor growing operation must have fixed camera coverage capable of identifying activity occurring within a minimum of twenty feet of the exterior, twenty-four hours a day. A motion detection lighting system may be employed to illuminate the gate area in low light conditions.

(e) Areas where marijuana is grown, cured or manufactured including destroying waste, shall have a camera placement in the room facing the primary entry door, and in adequate fixed positions, at a height which will provide a clear, unobstructed view of the regular activity without a sight blockage from lighting hoods, fixtures, or other equipment, allowing for the clear and certain identification of persons and activities at all times.

(f) All marijuana or marijuana-infused products that are intended to be removed or transported from marijuana producer to marijuana processor and/or marijuana processor to marijuana retailer shall be staged in an area known as the "quarantine" location for a minimum of twenty-four hours. Transport manifest with product information and weights must be affixed to the product. At no time during the quarantine period can the product be handled or moved under any circumstances and is subject to auditing by the liquor control board or designees.

(g) All camera recordings must be continuously recorded twenty-four hours a day. All surveillance recordings must be kept for a minimum of forty-five days on the licensee's recording device. All videos are subject to inspection by any liquor control board employee or law enforcement officer, and must be copied and provided to the board or law enforcement officer upon request.

(4) **Traceability:** To prevent diversion and to promote public safety, marijuana licensees must track marijuana from seed to sale. Licensees must provide the required information on a system specified by the board. All costs related to the reporting requirements are borne by the licensee. Marijuana seedlings, clones, plants, lots of usable marijuana or trim, leaves, and other plant matter, batches of extracts ((~~and~~)), marijuana-infused products, samples, and marijuana waste must be traceable from production through processing, and finally into the retail environment including being able to identify which lot was used as base material to create each batch of extracts or infused products. The following information is required and must be kept completely up-to-date in a system specified by the board:

(a) Key notification of "events," such as when a plant enters the system (moved from the seedling or clone area to the vegetation production area at a young age);

(b) When plants are to be partially or fully harvested or destroyed;

(c) When a lot or batch of marijuana, marijuana extract, marijuana-infused product, or marijuana waste is to be destroyed;

(d) When usable marijuana or marijuana-infused products are transported;

(e) Any theft of usable marijuana, marijuana seedlings, clones, plants, trim or other plant material, extract, infused product, seed, plant tissue or other item containing marijuana;

(f) There is a seventy-two hour mandatory waiting period after the notification described in this subsection is given before any plant may be destroyed ((~~or~~)), a lot or batch of marijuana ((~~or~~)), marijuana extract, marijuana-infused product, or marijuana waste may be destroyed;

(g) There is a twenty-four hour mandatory waiting period after the notification described in this subsection to allow for inspection before a lot of marijuana is transported from a producer to a processor;

(h) There is a twenty-four hour mandatory waiting period after the notification described in this subsection to allow for inspection before ((~~useable~~)) usable marijuana, or marijuana-infused products are transported from a processor to a retailer((~~.~~));

(i) Prior to reaching eight inches in height or width, each marijuana plant must be tagged and tracked individually, which typically should happened when a plant is moved from the seed germination or clone area to the vegetation production area;

(j) A complete inventory of all marijuana, seeds, plant tissue, seedlings, clones, all plants, lots of usable marijuana or trim, leaves, and other plant matter, batches of extract ((~~and~~)), marijuana-infused products, and marijuana waste;

(k) All point of sale records;

(l) Marijuana excise tax records;

(m) All samples sent to an independent testing lab, any sample of unused portion of a sample returned to a licensee, and the quality assurance test results;

(n) All free samples provided to another licensee for purposes of negotiating a sale;

(o) All samples used for testing for quality by the producer or processor;

(p) Samples containing usable marijuana provided to retailers;

(q) Samples provided to the board or their designee for quality assurance compliance checks; and

(r) Other information specified by the board.

(5) **Start-up inventory for marijuana producers.** Within fifteen days of starting production operations a producer must have all nonflowering marijuana plants physically on the licensed premises. The producer must ((~~immediately~~)), within twenty-four hours, record each marijuana plant that enters the facility in the traceability system during this fifteen day time frame. No flowering marijuana plants may be brought into the facility during this fifteen day time frame. After this fifteen day time frame expires, a producer may only start plants from seed or create clones from a marijuana plant located physically on their licensed premises, or purchase marijuana seeds, clones, or plants from another licensed producer.

(6) **Samples.** Free samples of usable marijuana may be provided by producers or processors, or used for product quality testing, as set forth in this section.

(a) Samples are limited to two grams and a producer may not provide any one licensed processor more than four grams of usable marijuana per month free of charge for the purpose of negotiating a sale. The producer must record the amount of each sample and the processor receiving the sample in the traceability system.

(b) Samples are limited to two grams and a processor may not provide any one licensed retailer more than four grams of usable marijuana per month free of charge for the purpose of negotiating a sale. The processor must record the amount of each sample and the retailer receiving the sample in the traceability system.

(c) Samples are limited to two units and a processor may not provide any one licensed retailer more than six ounces of marijuana infused in solid form per month free of charge for the purpose of negotiating a sale. The processor must record the amount of each sample and the retailer receiving the sample in the traceability system.

(d) Samples are limited to two units and a processor may not provide any one licensed retailer more than twenty-four ounces of marijuana-infused liquid per month free of charge for the purpose of negotiating a sale. The processor must record the amount of each sample and the retailer receiving the sample in the traceability system.

(e) Samples are limited to one-half gram and a processor may not provide any one licensed retailer more than one gram of marijuana-infused extract meant for inhalation per month free of charge for the purpose of negotiating a sale. The processor must record the amount of each sample and the retailer receiving the sample in the traceability system.

(f) Producers may sample one gram of ((~~useable~~)) usable marijuana per strain, per month for quality sampling. Sampling for quality may not take place at a licensed premises. Only the producer or employees of the licensee may sample the ((~~useable~~)) usable marijuana for quality. The producer must record the amount of each sample and the employee(s) conducting the sampling in the traceability system.

(g) Processors may sample one unit, per batch of a new edible marijuana-infused product to be offered for sale on the market. Sampling for quality may not take place at a licensed premises. Only the processor or employees of the licensee may sample the edible marijuana-infused product. The processor must record the amount of each sample and the employee(s) conducting the sampling in the traceability system.

(h) Processors may sample up to one quarter gram, per batch of a new marijuana-infused extract for inhalation to be offered for sale on the market. Sampling for quality may not take place at a licensed premises. Only the processor or employee(s) of the licensee may sample the marijuana-infused extract for inhalation. The processor must record the amount of each sample and the employee(s) conducting the sampling in the traceability system.

(i) The limits described in subsection (3) of this section do not apply to the usable marijuana in sample jars that may be provided to retailers described in WAC 314-55-105(8).

(j) Retailers may not provide free samples to customers.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-102 Quality assurance testing. (1) A third-party testing lab must be certified by the board or their vendor as meeting the board's accreditation and other requirements prior to conducting required quality assurance tests. Certified labs will receive a certification letter from the board and must conspicuously display this letter in the lab in plain sight of the customers. The board can summarily suspend a lab's certification if a lab is found out of compliance with the requirements of WAC 314-55-102.

(2) A person with financial interest in ((~~an accredited~~)) a certified third-party testing lab may not have direct or indirect financial interest in a licensed marijuana producer or processor for whom they are conducting required quality assurance tests. A person with direct or indirect financial interest in a certified third-party testing lab must disclose to the board by affidavit any direct or indirect financial interest in a licensed marijuana producer or processor.

((~~(2)~~)) (3) As a condition of ((~~accreditation~~)) certification, each lab must employ a scientific director responsible to ensure the achievement and maintenance of quality standards of practice. The scientific director shall meet the following minimum qualifications:

(a) Has earned, from a college or university accredited by a national or regional certifying authority a doctorate in the chemical or biological sciences and a minimum of two years' post-degree laboratory experience; or

(b) Has earned a master's degree in the chemical or biological sciences and has a minimum of four years' of post-degree laboratory experience; or

(c) Has earned a bachelor's degree in the chemical or biological sciences and has a minimum of six years of post-education laboratory experience.

(((~~(3)~~))) (4) As a condition of ((~~accreditation~~)) certification, labs must follow the most current version of the Cannabis Inflorescence and Leaf monograph published by the *American Herbal Pharmacopoeia* or notify the board what alternative scientifically valid testing methodology the lab is following for each quality assurance test. The board may require third-party validation of any monograph or analytical method followed by the lab to ensure the methodology produces scientifically accurate results prior to them using those standards when conducting required quality assurance tests.

(((~~(4)~~))) (5) As a condition of ((~~accreditation~~)) certification, the board may require third-party validation and ongoing monitoring of a lab's basic proficiency to correctly execute the analytical methodologies employed by the lab. The board may contract with a vendor to conduct the validation and ongoing monitoring described in this subsection. The lab shall pay all vendor fees for validation and ongoing monitoring directly to the vendor.

(((~~(5)~~))) (6) The lab must allow the board or their vendor to conduct physical visits and inspect related laboratory equipment, testing and other related records during normal business hours without advance notice.

(7) Labs must adopt and follow minimum good lab practices (GLPs), and maintain internal standard operating procedures (SOPs), and a quality control/quality assurance (QC/QA) program as specified by the board. The board or authorized third-party organization can conduct audits of a lab's GLPs, SOPs, QC/QA, and inspect all other related records.

(((~~(6)~~))) (8) The general body of required quality assurance tests for marijuana flowers((~~,~~)) and infused products((~~, and extracts~~)) may include moisture content, potency analysis, foreign matter inspection, microbiological screening, pesticide and other chemical residue and metals screening, and residual solvents levels.

(((~~(7)~~))) (9) Table of required quality assurance tests.

Product	Test(s) Required	Sample Size Needed to Complete all Tests
((~~Flowers to be sold as usable marijuana (see note below)~~))) Lots of marijuana flowers	1. Moisture content 2. Potency analysis 3. Foreign matter inspection 4. Microbiological screening	Up to 7 grams
((~~Flowers to be used to make an extract (nonsolvent) like kief, hashish, bubble hash, or infused dairy butter, or oils or fats derived from natural sources~~	~~None~~	~~None~~
~~Extract (nonsolvent) like kief, hashish, bubble hash or infused dairy butter, or oils or fats derived from natural sources~~	~~1. Potency analysis~~ ~~2. Foreign matter inspection~~ ~~3. Microbiological screening~~	~~Up to 7 grams~~
~~Flowers to be used to make an extract (solvent based), made with a CO_2 extractor, or with a food grade ethanol or glycerin~~	~~1. Foreign matter inspection~~ ~~2. Microbiological screening~~	~~Up to 7 grams~~))
Infused extract (solvent based) for inhalation made using n-butane, isobutane, propane, heptane, or other solvents or gases approved by the board of at least 99% purity	1. Potency analysis 2. Residual solvent test 3. Microbiological screening (only if using flowers and other plant material that failed initial test)	Up to 2 grams
((~~Extract~~)) Infused extract for inhalation made with a CO_2 extractor like hash oil	1. Potency analysis 2. Microbiological screening (only if using flowers and other plant material that failed initial test)	Up to 2 grams
((~~Extract~~)) Infused extract for inhalation made with ((~~food grade~~)) ethanol or other approved food grade solvent	1. Potency analysis 2. Microbiological screening (only if using flowers and other plant material that failed initial test)	Up to 2 grams
((~~Extract made with food grade glycerin or propylene glycol~~	~~1. Potency analysis~~	~~Up to 1 gram~~))
Infused extract (nonsolvent) meant for inhalation infused with kief, hashish, or bubble hash	1. Potency analysis 2. Microbiological screening	Up to 2 grams

Product	Test(s) Required	Sample Size Needed to Complete all Tests
Infused edible	1. Potency analysis 2. Microbiological screening	1 unit
Infused liquid like a soda or tonic	1. Potency analysis 2. Microbiological screening	1 unit
Infused topical	1. Potency analysis 2. Microbiological screening	1 unit

(((~~(8)~~))) (10) Independent testing labs may request additional sample material in excess of amounts listed in the table in subsection (((~~(7)~~))) (9) of this section for the purposes of completing required quality assurance tests. Labs certified as meeting the board's accreditation requirements may retrieve samples from a marijuana licensee's licensed premises and transport the samples directly to the lab and return any unused portion of the samples.

(((~~(9)~~))) (11) Labs certified as meeting the board's accreditation requirements are not limited in the amount of ((~~useable~~)) usable marijuana and marijuana products they may have on their premises at any given time, but they must have records to prove all marijuana and marijuana-infused products only for the testing purposes described in WAC 314-55-102.

(((~~(10)~~))) (12) At the discretion of the board, a producer or processor must provide an employee of the board or their designee samples in the amount listed in subsection (((~~(7)~~))) (9) of this section or samples of the growing medium, soil amendments, fertilizers, crop production aids, pesticides, or water for random compliance checks. Samples may be screened for pesticides and chemical residues, unsafe levels of metals, and used for other quality assurance tests deemed necessary by the board. All costs of this testing will be borne by the producer or processor.

(((~~(11)~~))) (13) No lot of usable flower or batch of marijuana-infused product may be sold or transported until the completion of all required quality assurance testing.

(((~~(12)~~))) (14) Any ((~~useable~~)) usable marijuana or marijuana-infused product that passed the required quality assurance tests may be labeled as "Class A." Only "Class A" ((~~useable~~)) usable marijuana or marijuana-infused product will be allowed to be sold.

(((~~(13)~~))) (15) If a lot of marijuana flowers fail a quality assurance test, any marijuana plant trim, leaf and other usable material from the same plants automatically fails quality assurance testing also. Upon approval of the board, a lot that fails a quality assurance test may be used to make a CO_2 or solvent based extract. After processing, the CO_2 or solvent based extract must still pass all required quality assurance tests in WAC 314-55-102.

(((~~(14)~~))) (16) At the request of the producer or processor, the board may authorize a retest to validate a failed test result on a case-by-case basis. All costs of the retest will be borne by the producer or the processor.

(17) Labs must report all required quality assurance test results directly into LCB's seed to sale traceability system within twenty-four hours of completion. Labs must also record in the seed to sale traceability system an acknowledgment of the receipt of samples from producers or processors and verify if any unused portion of the sample was destroyed or returned to the licensee.

NEW SECTION

WAC 314-55-200 How will the liquor control board identify marijuana, usable marijuana, and marijuana-infused products during checks of licensed businesses? Officers shall identify marijuana, usable marijuana, and marijuana-infused products during on-site inspections of licensed producers, processors, and retailers of marijuana by means of product in the traceability system, and/or by observation based on training and experience. Products that are undetermined to be marijuana, usable marijuana, and marijuana-infused products will be verified by the following:

(1) Officers may take a sample large enough for testing purposes;

(2) Field test kits may be used if available and appropriate for the type of product being verified; and

(3) Those samples not able to be tested with a field test kit may be tested through the Washington state toxicology or crime lab.

NEW SECTION

WAC 314-55-210 Will the liquor control board seize or confiscate marijuana, usable marijuana, and marijuana-infused products? The liquor control board may seize or confiscate marijuana, usable marijuana, and marijuana-infused products under the following circumstances:

(1) During an unannounced or announced administrative search or inspection of a licensed location, or vehicle involved in the transportation of marijuana products, where any product was found to be in excess of product limitations set forth in WAC 314-55-075, 314-55-077, and 314-55-079.

(2) Any product not properly logged in inventory records or untraceable product required to be in the traceability system.

(3) Marijuana, usable marijuana, and marijuana-infused product that are altered or not properly packaged and labeled in accordance with WAC 314-55-105.

(4) During a criminal investigation, officers shall follow seizure laws detailed in RCW 69.50.505 and any other applicable criminal codes.

NEW SECTION

WAC 314-55-220 What is the process once the board summarily orders marijuana, usable marijuana, or marijuana-infused products of a marijuana licensee to be destroyed? (1) The board may issue an order to summarily

destroy marijuana, usable marijuana, or marijuana-infused products after the board's enforcement division has completed a preliminary staff investigation of the violation and upon a determination that immediate destruction of marijuana, usable marijuana, or marijuana-infused products is necessary for the protection or preservation of the public health, safety, or welfare.

(2) Destruction of any marijuana, usable marijuana, or marijuana-infused products under this provision shall take effect immediately upon personal service on the licensee or employee thereof of the summary destruction order unless otherwise provided in the order.

(3) When a license has been issued a summary destruction order by the board, an adjudicative proceeding for the associated violation or other action must be promptly instituted before an administrative law judge assigned by the office of administrative hearings. If a request for an administrative hearing is timely filed by the licensee, then a hearing shall be held within ninety days of the effective date of the summary destruction ordered by the board.

NEW SECTION

WAC 315-55-230 What are the procedures the liquor control board will use to destroy or donate marijuana, usable marijuana, and marijuana-infused products to law enforcement? (1) The liquor control board may require a marijuana licensee to destroy marijuana, usable marijuana, and marijuana-infused products found in a licensed establishment to be in excess of product limits set forth in WAC 314-55-075, 314-55-077, and 314-55-079.

(2) Destruction of seized marijuana, usable marijuana, marijuana-infused products, or confiscated marijuana after case adjudication, will conform with liquor control board evidence policies, to include the option of donating marijuana, usable marijuana, and marijuana-infused products, set for destruction, to local and state law enforcement agencies for training purposes only.

(3) Marijuana, usable marijuana, and marijuana-infused products set for destruction shall not reenter the traceability system or market place.

WSR 14-04-064
PROPOSED RULES
LIQUOR CONTROL BOARD

[Filed January 29, 2014, 10:46 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-07-028.

Title of Rule and Other Identifying Information: Revisions to current rules in chapter 314-55 WAC, Marijuana licenses, application process, requirements and reporting.

Hearing Location(s): Washington State Liquor Control Board, Board Room, 3000 Pacific Avenue S.E., Olympia, WA 98504, on March 12, 2014, at 10:00 a.m.

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Assistance for Persons with Disabilities: Contact Karen McCall by March 12, 2014, (360) 664-1631.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: These rules are to further clarify current rules implementing I-502 and include additional requirements for marijuana retail licensees as well as marijuana processor and producer licensees.

Reasons Supporting Proposal: Requests from marijuana license applicants of all types indicated a need for further clarification for this new industry in the state of Washington.

Statutory Authority for Adoption: RCW 69.50.342, 69.50.345.

Statute Being Implemented: RCW 69.50.342, 69.50.345.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state liquor control board, governmental.

Name of Agency Personnel Responsible for Drafting: Karen McCall, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1631; Implementation: Alan Rathbun, Licensing Director, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1615; and Enforcement: Justin Nordhorn, Enforcement Chief, 3000 Pacific Avenue S.E., Olympia, WA 98504, (360) 664-1726.

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January 29, 2014
Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-075 What is a marijuana producer license and what are the requirements and fees related to a marijuana producer license? (1) A marijuana producer license allows the licensee to produce, harvest, trim, dry, cure, and package marijuana into lots for sale at wholesale to marijuana processor licensees and to other marijuana producer licensees. A marijuana producer can also produce and sell marijuana plants, seed, and plant tissue culture to other marijuana producer licensees. Marijuana production must take place within a fully enclosed secure indoor facility or greenhouse with rigid walls, a roof, and doors. Outdoor production may take place in nonrigid greenhouses, other structures, or an expanse of open or cleared ground fully enclosed by a physical barrier. To obscure public view of the premises, outdoor production must be enclosed by a sight obscure wall or fence at least eight feet high. Outdoor producers must meet security requirements described in WAC 314-55-083.

(2) The application fee for a marijuana producer license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(3) The annual fee for issuance and renewal of a marijuana producer license is one thousand dollars. The board will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(4) The board will initially limit the opportunity to apply for a marijuana producer license to a thirty-day calendar window beginning with the effective date of this section. In order for a marijuana producer application license to be considered it must be received no later than thirty days after the effective date of the rules adopted by the board. The board may reopen the marijuana producer application window after the initial evaluation of the applications received and at subsequent times when the board deems necessary.

(5) Any entity and/or principals within any entity are limited to no more than three marijuana producer licenses.

(6) The maximum amount of space for marijuana production is limited to two million square feet. Applicants must designate on their operating plan the size category of the production premises and the amount of actual square footage in their premises that will be designated as plant canopy. There are three categories as follows:

(a) Tier 1 – Less than two thousand square feet;

(b) Tier 2 – Two thousand square feet to ten thousand square feet; and

(c) Tier 3 – Ten thousand square feet to thirty thousand square feet.

(7) The board may reduce a licensee's or applicant's square footage designated to plant canopy for the following reasons:

(a) If the amount of square feet of production of all licensees exceeds the maximum of two million square feet the board will reduce the allowed square footage by the same percentage.

(b) If fifty percent production space used for plant canopy in the licensee's operating plan is not met by the end of the first year of operation the board may reduce the tier of licensure.

(8) If the total amount of square feet of marijuana production exceeds two million square feet, the board reserves the right to reduce all licensee's production by the same percentage or reduce licensee production by one or more tiers by the same percentage.

(9) The maximum allowed amount of marijuana on a producer's premises at any time is as follows:

(a) Outdoor or greenhouse grows – One and one-quarter of a year's harvest; or

(b) Indoor grows – Six months of their annual harvest.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-077 What is a marijuana processor license and what are the requirements and fees related to a marijuana processor license? (1) A marijuana processor license allows the licensee to process, package, and label usable marijuana and marijuana-infused products for sale at wholesale to marijuana retailers.

(2) A marijuana processor is allowed to blend tested useable marijuana from multiple lots into a single package for sale to a marijuana retail licensee providing the label requirements for each lot used in the blend are met and the percentage by weight of each lot is also included on the label.

(3) The application fee for a marijuana processor license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(4) The annual fee for issuance and renewal of a marijuana processor license is one thousand dollars. The board will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(5) The board will initially limit the opportunity to apply for a marijuana processor license to a thirty-day calendar window beginning with the effective date of this section. In order for a marijuana processor application license to be considered it must be received no later than thirty days after the effective date of the rules adopted by the board. The board may reopen the marijuana processor application window after the initial evaluation of the applications that are received and processed, and at subsequent times when the board deems necessary.

(6) Any entity and/or principals within any entity are limited to no more than three marijuana processor licenses.

(7) Marijuana processor licensees are allowed to have a maximum of six months of their average useable marijuana and six months average of their total production on their licensed premises at any time.

(8) A marijuana processor must accept returns of products and sample jars from marijuana retailers for destruction, but is not required to provide refunds to the retailer.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-079 What is a marijuana retailer license and what are the requirements and fees related to a marijuana retailer license? (1) A marijuana retailer license allows the licensee to sell only usable marijuana, marijuana-infused products, and marijuana paraphernalia at retail in retail outlets to persons twenty-one years of age and older.

(2) Marijuana extracts, such as hash, hash oil, shatter, and wax can be infused in products sold in a marijuana retail store, but RCW 69.50.354 does not allow the sale of extracts that are not infused in products. A marijuana extract does not meet the definition of a marijuana-infused product per RCW 69.50.101.

(3) Internet sales and delivery of product to customers is prohibited.

(4) The application fee for a marijuana retailer's license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(5) The annual fee for issuance and renewal of a marijuana retailer's license is one thousand dollars. The board will conduct random criminal history checks at the time of

renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(6) Marijuana retailers may not sell marijuana products below their acquisition cost.

(7) Marijuana retailer licensees are allowed to have a maximum of four months of their average inventory on their licensed premises at any given time.

(8) A marijuana retailer may transport product to other locations operated by the licensee or to return product to a marijuana processor as outlined in the transportation rules in WAC 314-55-085.

(9) A marijuana retailer may not accept a return of product that has been opened.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-084 Production of marijuana. Only the following specified soil amendments, fertilizers, other crop production aids, and pesticides may be used in the production of marijuana:

(1) ((~~Materials listed or registered by the Washington state department of agriculture (WSDA) or Organic Materials Review Institute (OMRI) as allowable for use in organic production, processing, and handling under the U.S. Department of Agriculture's national organics standards, also called the National Organic Program (NOP), consistent with requirements at 7 C.F.R. Part 205.~~

~~(2)~~)) Pesticides registered by WSDA under chapter 15.58 RCW as allowed for use in the production, processing, and handling of marijuana. Pesticides must be used consistent with the label requirements.

(((~~3~~))) (2) Commercial fertilizers registered by WSDA under chapter 15.54 RCW.

(((~~4~~))) (3) Potting soil and other growing media available commercially in the state of Washington may be used in marijuana production. Producers growing outdoors are not required to meet land eligibility requirements outlined in 7 C.F.R. Part 205.202.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-085 What are the transportation requirements for a marijuana licensee? (1) **Notification of shipment.** Upon transporting any marijuana or marijuana product, a producer, processor ((~~or~~)), retailer, or certified third-party testing lab shall notify the board of the type and amount and/or weight of marijuana and/or marijuana products being transported, the name of transporter, information about the transporting vehicle, times of departure and expected delivery. This information must be reported in the traceability system described in WAC 314-55-083(4).

(2) **Receipt of shipment.** Upon receiving the shipment, the licensee receiving the product shall report the amount and/or weight of marijuana and/or marijuana products received in the traceability system.

(3) **Transportation manifest.** A complete printed transport manifest on a form provided by the board containing all information required by the board must be kept with the product at all times.

(4) **Records of transportation.** Records of all transportation must be kept for a minimum of three years at the licensee's location.

(5) **Transportation of product.** Marijuana or marijuana products that are being transported must meet the following requirements:

(a) Only the marijuana licensee ((~~or~~)), an employee of the licensee, or a certified testing lab may transport product;

(b) Marijuana or marijuana products must be in a sealed package or container approved by the board pursuant to WAC 314-55-105;

(c) Sealed packages or containers cannot be opened during transport;

(d) Marijuana or marijuana products must be in a locked, safe and secure storage compartment that is secured to the inside body/compartment of the vehicle transporting the marijuana or marijuana products;

(e) Any vehicle transporting marijuana or marijuana products must travel directly from the shipping licensee to the receiving licensee and must not make any unnecessary stops in between except to other facilities receiving product.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-089 What are the tax and reporting requirements for marijuana licensees? (1) Marijuana licensees must submit monthly report(s) and payments to the board. The required monthly reports must be:

(a) On a form or electronic system designated by the board;

(b) Filed every month, including months with no activity or payment due;

(c) Submitted, with payment due, to the board on or before the twentieth day of each month, for the previous month. (For example, a report listing transactions for the month of January is due by February 20th.) When the twentieth day of the month falls on a Saturday, Sunday, or a legal holiday, the filing must be postmarked by the U.S. Postal Service no later than the next postal business day;

(d) Filed separately for each marijuana license held; and

(e) All records must be maintained and available for review for a three-year period on licensed premises (see WAC 314-55-087).

(2) **Marijuana producer licensees:** On a monthly basis, marijuana producers must maintain records and report purchases from other licensed marijuana producers, current production and inventory on hand, sales by product type, and lost and destroyed product in a manner prescribed by the board.

A marijuana producer licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each wholesale sale to a licensed marijuana processor or producer.

(3) **Marijuana processor licensees:** On a monthly basis, marijuana processors must maintain records and report purchases from licensed marijuana producers, production of marijuana-infused products, sales by product type to mari-

juana retailers, and lost and/or destroyed product in a manner prescribed by the board.

A marijuana processor licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each wholesale sale of usable marijuana and marijuana-infused product to a licensed marijuana retailer.

(4) **Marijuana retailer's licensees:** On a monthly basis, marijuana retailers must maintain records and report purchases from licensed marijuana processors, sales by product type to consumers, and lost and/or destroyed product in a manner prescribed by the board.

A marijuana retailer licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each retail sale of usable marijuana or marijuana-infused products.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-092 What if a marijuana licensee fails to report or pay, or reports or pays late? (1) If a marijuana licensee does not submit its monthly reports and payment(s) to the board as required in WAC 314-55-089: The licensee is subject to penalties.

Penalties: A penalty of two percent per month will be assessed on any payments postmarked after the twentieth day of the month following the month of sale. When the twentieth day of the month falls on a Saturday, Sunday, or a legal holiday, the filing must be postmarked by the U.S. Postal Service no later than the next postal business day. Absent a postmark, the date received at the liquor control board or authorized designee, will be used to assess the penalty of two percent per month on payments received after the twentieth day of the month following the month of sale.

(2) Failure to make a report and/or pay the license taxes and/or penalties in the manner and dates outlined in WAC 314-55-089 will be sufficient grounds for the board to suspend or revoke a marijuana license.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-104 Marijuana processor license extraction requirements. (1) Processors are limited to certain methods, equipment, solvents, gases and mediums when creating marijuana extracts.

(2) Processors may use the hydrocarbons N-butane, isobutane, propane, or heptane or other solvents or gases exhibiting low to minimal potential human health-related toxicity approved by the board. These solvents must be of at least ninety-nine percent purity and a processor must use them in a professional grade closed loop extraction system designed to recover the solvents, work in ((~~a spark free~~)) an environment with proper ventilation, ((~~and follow all applicable local fire, safety and building codes in processing and the storage of the solvents~~)) controlling all sources of ignition where a flammable atmosphere is or may be present.

(3) Processors may use a professional grade closed loop CO_2 gas extraction system where every vessel is rated to a minimum of nine hundred pounds per square inch ((~~and follow all applicable local fire, safety and building codes in processing and the storage of the solvents~~)). The CO_2 must be of at least ninety-nine percent purity.

(4) Professional grade closed loop systems used by processors must be commercially manufactured and built to codes of recognized and generally accepted good engineering practices, such as:

(a) The American Society of Mechanical Engineers (ASME);

(b) American National Standards Institute (ANSI);

(c) Underwriters Laboratories (UL); or

(d) The American Society for Testing and Materials (ASTM).

(5) Professional closed loop systems, other equipment used, the extraction operation, and facilities must be approved for their use by the local fire code official and meet any required fire, safety, and building code requirements specified in:

(a) Title 296 WAC;

(b) National Fire Protection Association (NFPA) standards;

(c) International Building Code (IBC);

(d) International Fire Code (IFC); and

(e) Other applicable standards including following all applicable fire, safety, and building codes in processing and the handling and storage of the solvent or gas.

(6) Processors may use heat, screens, presses, steam distillation, ice water, and other methods without employing solvents or gases to create kief, hashish, bubble hash, or infused dairy butter, or oils or fats derived from natural sources, and other extracts.

(((~~(5)~~))) (7) Processors may use food grade glycerin, ethanol, and propylene glycol solvents to create extracts.

(((~~(6)~~))) (8) Processors creating marijuana extracts must develop standard operating procedures, good manufacturing practices, and a training plan prior to producing extracts for the marketplace. Any person using solvents or gases in a closed looped system to create marijuana extracts must be fully trained on how to use the system, have direct access to applicable material safety data sheets and handle and store the solvents and gases safely.

(((~~(7)~~))) (9) Parts per million for one gram of finished extract cannot exceed 500 parts per million or residual solvent or gas when quality assurance tested per RCW 69.50.348.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-105 Packaging and labeling requirements. (1) All usable marijuana and marijuana-infused products must be stored behind a counter or other barrier to ensure a customer does not have direct access to the product.

(2) Any container or packaging containing usable marijuana or marijuana-infused products must protect the product from contamination and must not impart any toxic or deleterious substance to the usable marijuana or marijuana product.

(3) Upon the request of a retail customer, a retailer must disclose the name of the accredited third-party testing lab and results of the required quality assurance test for any usable

marijuana or other marijuana-infused product the customer is considering purchasing.

(4) Usable marijuana and marijuana-infused products may not be labeled as organic unless permitted by the United States Department of Agriculture in accordance with the Organic Foods Production Act.

(5) The accredited third-party testing lab and required results of the quality assurance test must be included with each lot and disclosed to the customer buying the lot.

(6) A marijuana producer must make quality assurance test results available to any processor purchasing product. A marijuana producer must label each lot of marijuana with the following information:

(a) Lot number;

(b) UBI number of the producer; and

(c) Weight of the product.

(7) Marijuana-infused products meant to be eaten, swallowed, or inhaled, must be packaged in child resistant packaging in accordance with Title 16 C.F.R. 1700 of the Poison Prevention Packaging Act or use standards specified in this subsection. Marijuana-infused product in solid or liquid form may be packaged in plastic four mil or greater in thickness and be heat sealed with no easy-open tab, dimple, corner, or flap as to make it difficult for a child to open and as a tamper-proof measure. Marijuana-infused product in liquid form may also be sealed using a metal crown cork style bottle cap.

(8) A processor may provide a retailer free samples of usable marijuana packaged in a sample jar protected by a plastic or metal mesh screen to allow customers to smell the product before purchase. The sample jar may not contain more than three and one-half grams of usable marijuana. The sample jar and the usable marijuana within may not be sold to a customer and must be ((~~either~~)) returned to the licensed processor who ((~~provide~~)) provided the usable marijuana and sample jar ((~~or destroyed by the retailer after use in the manner described in WAC 314-55-097 and noted in the traceability system~~)).

(9) A producer or processor may not treat or otherwise adulterate usable marijuana with any organic or nonorganic chemical or other compound whatsoever to alter the color, appearance, weight, or smell of the usable marijuana.

(10) Labels must comply with the version of NIST Handbook 130, Uniform Packaging and Labeling Regulation adopted in chapter 16-662 WAC.

(11) **All usable marijuana when sold at retail must include accompanying material that contains the following warnings that state:**

(a) "Warning: This product has intoxicating effects and may be habit forming. Smoking is hazardous to your health";

(b) "There may be health risks associated with consumption of this product";

(c) "Should not be used by women that are pregnant or breast feeding";

(d) "For use only by adults twenty-one and older. Keep out of reach of children";

(e) "Marijuana can impair concentration, coordination, and judgment. Do not operate a vehicle or machinery under the influence of this drug";

(f) Statement that discloses all pesticides applied to the marijuana plants and growing medium during production and processing.

(12) **All marijuana-infused products sold at retail must include accompanying material that contains the following warnings that state:**

(a) "There may be health risks associated with consumption of this product";

(b) "This product is infused with marijuana or active compounds of marijuana";

(c) "Should not be used by women that are pregnant or breast feeding";

(d) "For use only by adults twenty-one and older. Keep out of reach of children";

(e) "Products containing marijuana can impair concentration, coordination, and judgment. Do not operate a vehicle or machinery under the influence of this drug";

(f) "Caution: When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or more hours";

(g) Statement that discloses all pesticides applied to the marijuana plants and growing medium during production of the base marijuana used to create the extract added to the infused product; and

(h) Statement that discloses the type of extraction method, including any solvents, gases, or other chemicals or compounds used to produce or that are added to the extract.

(13) **Labels affixed to the container or package containing usable marijuana sold at retail must include:**

(a) The business or trade name and Washington state unified business identifier number of the licensees that produced, processed, and sold the usable marijuana;

(b) Lot number;

(c) Concentration of THC, THCA, CBD, including a total of active cannabinoids (potency profile);

(d) Net weight in ounces and grams or volume as appropriate;

(e) Warnings that state: "This product has intoxicating effects and may be habit forming";

(f) Statement that "This product may be unlawful outside of Washington state";

(g) Date of harvest((~~.~~)); and

(h) The board may create a logo that must be placed on all usable marijuana and marijuana-infused products.

(14) **Sample label mock up for a container or package containing usable marijuana sold at retail with required information:**

UBI: 1234567890010001 Lot#: 1423

Date of Harvest: 4-14

The Best Resins

Blueberry haze

16.7 % THC 1.5% CBD

Warning – This product has intoxicating effect and may be habit forming

THIS PRODUCT IS UNLAWFUL OUTSIDE WASHINGTON STATE

Net weight: 7 grams

(15) **Labels affixed to the container or package containing marijuana-infused products sold at retail must include:**

(a) The business or trade name and Washington state unified business identifier number of the licensees that produced, processed, and sold the usable marijuana;

(b) Lot numbers of all base marijuana used to create the extract;

(c) Batch number;

(d) Date manufactured;

(e) Best by date;

(f) Products meant to be eaten or swallowed, recommended serving size and the number of servings contained within the unit, including total milligrams of active tetrahydrocannabinol (THC), or Delta 9;

(g) Net weight in ounces and grams, or volume as appropriate;

(h) List of all ingredients and any allergens;

(i) "Caution: When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or more hours.";

(j) If a marijuana extract was added to the product, disclosure of the type of extraction process and any solvent, gas, or other chemical used in the extraction process, or any other compound added to the extract;

(k) Warnings that state: "This product has intoxicating effects and may be habit forming";

(l) Statement that "This product may be unlawful outside of Washington state";

(m) The board may create a logo that must be placed on all usable marijuana and marijuana-infused products.

(16) **Sample label mock up (front and back) for a container or package containing marijuana-infused products sold at retail with required information:**

(Front of label)

UBI: 1234567890010001 Batch#: 5463

The Best Resins

Space cake

CAUTION: when eaten the effects of this product can be delayed by as much as two hours.

Net weight: 6oz (128grams)

THIS PRODUCT IS UNLAWFUL OUTSIDE WASHINGTON STATE

(Back of label)

Manufactured at: 111 Old Hwy Rd., Mytown, WA on 1/14/14 Best by 2/1/14

INGREDIENTS: Flour, Butter, Canola oil, Sugar, Chocolate, Marijuana, Strawberries,

CONTAINS ALLERGENS: Milk, Wheat,

Serving size: 10 MG of THC

This product contains 10 servings and a total of 100 MG of THC

Warning- This product has intoxicating effects and may be habit forming

WSR 14-04-068

PROPOSED RULES

OFFICE OF THE STATE TREASURER

(State Finance Committee)

[Filed January 29, 2014, 1:40 p.m.]

Continuance of WSR 14-03-043.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: Chapter 210-02 WAC, School bond guarantee program.

Hearing Location(s): Office of the State Treasurer, Capitol Court Building, Room 204, 1110 Capitol Way S.W., Olympia, WA 98504, on March 4, 2014, at 9:00 a.m.

Date of Intended Adoption: March 5, 2014.

Submit Written Comments to: Johnna S. Craig, 1110 Capitol Way S.W., P.O. Box 40200, Olympia, WA 98504, e-mail Johnna.craig@tre.wa.gov, fax (360) 704-5181, by March 3, 2014.

Assistance for Persons with Disabilities: Contact Johnna S. Craig by March 3, 2014, 7-1-1 Telecommunications relay services.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Office of the state treasurer, governmental.

Name of Agency Personnel Responsible for Drafting: Johnna S. Craig, 1110 Capitol Way S.W., Olympia, WA 98504, (360) 902-8912; Implementation: Kate Manley, 416 Sid Snyder Avenue S.W., Legislative Building, Room 230, Olympia, WA 98504, (360) 902-9028; and Enforcement: Ellen L. Evans, 416 Sid Snyder Avenue S.W., Legislative Building, Room 230, Olympia, WA 98504, (360) 902-9007.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed amended rules are "rules relating only to internal governmental operations that are not subject to violation by a nongovernmental entity" as stated in RCW 34.05.310 and therefore such requirement is not applicable.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules are not significant legislative rules adopted by one of the specifically enumerated departments set forth in RCW 34.05.328 (5)(a)(i). In addition, this section has not voluntarily been made applicable to the proposed rules.

January 29, 2014
Ellen Evans
Deputy Treasurer
for Debt Management

WSR 14-04-069
PROPOSED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed January 30, 2014, 8:56 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-15-013.

Title of Rule and Other Identifying Information: Amends WAC 181-78A-255 to clarify the program requirements for data collection.

Hearing Location(s): Holiday Inn, Downtown Everett, 3105 Pine Street, Everett, WA 98201, on March 13, 2014, at 8:30.

Date of Intended Adoption: March 13, 2014.

Submit Written Comments to: David Brenna, 600 Washington Street, Room 400, Olympia, WA 98504, e-mail david.brenna@k12.wa.us, fax (360) 586-4548, by March 6, 2014.

Assistance for Persons with Disabilities: Contact David Brenna by March 6, 2014, (360) 725-6238.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Removes the requirement for a memorandum of understanding and details data collection requirements.

Reasons Supporting Proposal: Clarifies data requirements.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: David Brenna, P.O. Box 42736 [47236], Olympia, WA 98504, (360) 725-6238.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed amendment does not have an impact on small business and therefore does not meet the requirements for a statement under RCW 19.85.030 (1) or (2).

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting David Brenna, 600 Washington Street, Olympia, WA 98504, phone (360) 725-6238, fax (360) 586-4548, e-mail david.brenna@k12.wa.us.

January 30, 2014
David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 10-17-029, filed 8/9/10, effective 9/9/10)

WAC 181-78A-255 Approval standard—Accountability. Building on the mission to prepare educators who demonstrate a positive impact on student learning, the following evidence shall be evaluated to determine whether each preparation program is in compliance with the program approval standards of WAC 181-78A-220(2).

(1) Each approved educator preparation program shall maintain an assessment system that:

(a) Assesses outcomes in alignment with the conceptual framework and state standards.

(b) Systematically and comprehensively gathers evidence on:

(i) Candidate learning;

(ii) Program operations, including placement rates, clinical experiences, and candidate characteristics.

(c) Collects candidate work samples that document positive impact on student learning.

(d) Aggregates key data over time.

(e) Incorporates perspectives of faculty, candidates, and P-12 partners.

(f) Includes processes and safeguards that ensure fair and unbiased assessment of candidates.

(g) Provides for regular analysis of assessment results.

(h) Is systematically linked to program decision-making processes.

(2) Each approved program shall ((~~reach agreement with the professional educator standards board on the delivery of data as described in a memorandum of understanding. The memorandum will detail the minimum data requirements for approved programs~~)) maintain a data system that exhibits:

(a) Data structure;

(b) Standards for security and access; and

(c) Guidelines for data governance.

(3) Each approved education preparation program shall collect and report data in accordance with the data manuals adopted by the professional educator standards board.

WSR 14-04-087
PROPOSED RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed February 3, 2014, 5:16 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-15-072.

Title of Rule and Other Identifying Information: Chapter 182-543 WAC, Durable medical equipment and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling (360) 725-1000), on March 11, 2014, at 10:00 a.m.

Date of Intended Adoption: Not sooner than March 12, 2014.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th Avenue, Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, by 5:00 p.m. on March 11, 2014.

Assistance for Persons with Disabilities: Contact Kelly Richters by March 3, 2014, TTY (800) 848-5429 or (360) 725-1307 or e-mail kelly.richters@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules:

- Include complex rehabilitation technology (CRT) products and services for complex medical-need clients including a new reimbursement section for CRT.
- Revise how the agency sets, evaluates, and updates the maximum allowable fees for wheelchair purchase.
- Update the eligibility section to cross reference WAC 182-501-0060 Scope of services.
- Add naturopathic physicians to list of eligible providers who can prescribe and write valid prescription[s] under this chapter.
- Correct the documentation requirements for clients in skilled nursing facilities.
- Add full electric beds to the list of noncovered personal or comfort items.
- Clarify that the agency does not pay for duplicate equipment, including equipment the agency has authorized for the client but which may not have been delivered to client yet.
- Change the date the agency calculates reimbursement rates from July 31 of each year to January 31 of each year to keep dates consistent in all sections.
- Make housekeeping changes such as fixing cross-references and updating department to agency.

Reasons Supporting Proposal: CRT is directed under ESSB [E2SSB] 1445.

Statutory Authority for Adoption: RCW 41.05.021; ESSB [E2SSB] 1445.

Statute Being Implemented: RCW 41.05.021; ESSB [E2SSB] 1445.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Wendy Barcus, P.O. Box 42716, Olympia, WA 98504, (360) 725-1306; Implementation and Enforcement: Dianne Baum, P.O. Box 45506, Olympia, WA 98504, (360) 725-1590.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The agency has analyzed the proposed rules and concludes they do not impose more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

February 3, 2014
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~~)) to be 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~~)) they are:

(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, 182-543-7100, and 182-543-7300 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~~)) 182-501-0165 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)" - 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.

"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, certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of clients, 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 CRT for the complex needs patient;

(5) Provides service and repairs by qualified technicians for all CRT 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 of the delivered CRT.

"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 (HCA 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 the agency's 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~~)). The proof of delivery slip 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 these have been 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 these have been determined to be 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~~)) heart 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 these have been determined to be ineffective in meeting positioning needs (nature ((~~if~~)) of 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)~~)) COPD or CHF with aspiration risk or shortness of breath that causes the need for an immediate change of upper body positioning 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~~)) in 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~~)) where 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~~)) and 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~~)) an agency Prescription Form (((~~DSHS~~)) HCA 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 submitted 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~~)) an 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~~)) HCA 13-794); and

(c) Medical Necessity for Wheelchair Purchase (for home clients only) form (((~~DSHS~~)) HCA 13-727) from the client's physician or therapist. The date on this form (((~~DSHS~~)) HCA 13-727) must not be prior to the date on the Prescription Form (((~~DSHS~~)) HCA 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, for six months or less, the department~~)) 182-501-0165, the agency rents or purchases 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~~)) HCA 13-794);

(c) A completed Medical Necessity for Wheelchair Purchase (for home clients only) form (((~~DSHS~~)) HCA 13-727). The date on this form (((~~DSHS~~)) HCA 13-727) must not be dated prior to the date on the Prescription Form (((~~DSHS~~)) HCA 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~~)) HCA 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 within 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, per limb.

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

(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~~)) or 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 submitted 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~~)) HCA 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)~~)) copy of the telephone order, signed by the physician for the wheelchair accessories and modifications;

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (((~~DSHS~~)) HCA 13-729). The date on this form ((~~(DSHS 13-727)~~)) (HCA 13-729) must not be prior to the date on the ((~~Prescription form (DSHS-13-794)~~)) telephone order. 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~~)) HCA 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~~)) or related repairs ((~~and~~)) or 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 part((~~s~~)) 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~~)) DME 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) Full electric beds;

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

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

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

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

((~~(g)~~)) (h) Diverter valves and handheld showers for bathtub;

((~~(h)~~)) (i) Eating/feeding utensils;

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

((~~(j)~~)) (k) Health club memberships;

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

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

((~~(m)~~)) (n) Impotence devices;

((~~(n)~~)) (o) Insect repellants;

((~~(o)~~)) (p) Massage equipment;

((~~(p)~~)) (q) 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)~~)) (r) 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)~~)) (s) Page turners;

((~~(s)~~)) (t) Radio and television;

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

((~~(u)~~)) (v) 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, or 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~~)) DME, 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 equipment((~~s~~)) as required in this chapter, in 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 provider 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 equipment((~~s~~)) 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 that the client already owns ((~~or~~)), rents, or that the agency has authorized for the client. 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, fre-

quency, or duration of certain covered medical supplies and equipment(MSE), durable medical equipment (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 durable medical equipment (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) If a client ((~~may be~~)) is 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~~)) an 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 182-543-9100 Reimbursement method—Other DME. (1) The agency sets, evaluates and updates the maximum allowable fees for purchased other durable medical equipment (DME) at least once yearly using one or more of the following:

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

(b) A pricing cluster; or

(c) On a by report basis.

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

(a) A pricing cluster is based on a specific 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 the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

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

(iv) Cost.

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

(3) The 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 eighty percent of the manufacturer's list or manufacturer's suggested retail price (MSRP) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

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

(a) For items with a monthly rental rate on the current medicare fee schedule as established by ((~~the federal Centers for Medicare and Medicaid Services (~~))CMS((~~)~~)), the agency equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;

(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule as established by ((~~the federal Centers for Medicare and Medicaid Services (~~))CMS((~~)~~)), the agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by ((~~the federal Centers for Medicare and Medicaid Services (~~))CMS((~~)~~)), the agency considers the maximum allowable monthly reimbursement rate as by report. The agency calculates the monthly reimbursement rate for these items at one-tenth of eighty percent of the manufacturer's list or ((~~manufacturer's suggested retail price (~~))MSRP((~~)~~)).

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

(a) For items with a daily rental rate on the current medicare fee schedule as established by ((~~the Centers for Medicare and Medicaid Services (~~))CMS((~~)~~)), the agency equates its maximum allowable fee for daily rental to the current medicare daily rental rate;

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

(c) For items not included in the current medicare fee schedule as established by CMS, the agency considers the maximum allowable daily reimbursement rate as by report. The agency calculates the daily reimbursement rate at one-three-hundredth of eighty percent of the manufacturer's list or ((~~manufacturer's suggested retail price (~~))MSRP((~~)~~)) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

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

(a) An inpatient hospital client;

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

(c) Terminally ill and receiving hospice care; or

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

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

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

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

(9) 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.

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 (BR) 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 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.

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HEALTH CARE AUTHORITY
(Washington Apple Health)
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Original Notice.

Preproposal statement of inquiry was filed as WSR 13-08-054.

Title of Rule and Other Identifying Information: Chapters 182-535 and 182-535A WAC, dental-related services and orthodontic services; WAC 182-535-1050 Dental-related services—Definitions, 182-535-1060 Dental-related services—Client eligibility, 182-535-1066 Dental-related services—Medical care services clients, 182-535-1070 Dental-related services—Provider information, 182-535-1079 Dental-related services—General, 182-535-1080 Dental-related services—Covered—Diagnostic, 182-535-1082 Dental-related services—Covered—Preventive services, 182-535-1084 Dental-related services—Covered—Restorative services, 182-535-1086 Dental-related services—Covered—Endodontic services, 182-535-1088 Dental-related services—Covered—Periodontic services, 182-535-1090 Dental-related services—Covered—Prosthodontics (removable), 182-535-1092 Dental-related services—Covered—Maxillofacial prosthetic services, 182-535-1094 Dental-related services—Covered—Oral and maxillofacial surgery services, 182-535-1096 Dental-related services—Covered—Orthodontic services, 182-535-1098 Dental-related services—Covered—Adjunctive general services, 182-535-1099 Dental-related services for clients of the developmental disabilities administration of DSHS, 182-535-1100 Dental-related services—Not covered, 182-535-1220 Obtaining prior authorization for dental-related services, 182-535-1245 Access to baby and child dentistry (ABCD) program, 182-535-1350 Payment methodology for dental-related services, 182-535-1400 Payment for dental-related services, 182-535-1550 Payment for dental-related services provided out-of-state, 182-535A-0010 Orthodontic services—Definitions, 182-535A-0020 Orthodontic treatment and orthodontic services—Client eligibility, 182-535A-0030 Orthodontic treatment and orthodontic services—Provider eligibility, 182-535A-0040 Orthodontic treatment and orthodontic services—Covered, noncovered, and limitations to coverage, 182-535A-0050 Orthodontic treatment and orthodontic-related services—Authorization and prior authorization, and 182-535A-0060 Orthodontic treatment and orthodontic-related services—Payments.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling (360) 725-1000), on March 11, 2014, at 10:00 a.m.

Date of Intended Adoption: Not sooner than March 12, 2014.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th Avenue, Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, by 5:00 p.m. on March 11, 2014.

Assistance for Persons with Disabilities: Contact Kelly Richters by March 3, 2014, TTY (800) 848-5429 or (360) 725-1307 or e-mail kelly.richters@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Restore the adult dental benefit (effective January 1, 2014).

(1) Repeal oral health care services section from chapter 182-531 WAC, Physician services *(due to restoration of the adult dental benefit*).

(2) Add new section for medical care services clients *(due to restoration of adult dental benefit)*.

(3) Add coverage for tobacco cessation for pregnant woman.

(4) Correct discrepancies between covered and noncovered sections – cleaned up age limitations, etc.

(5) Add additional coverage for nursing facility clients to be consistent with DD clients.

(6) Clarify existing policies and updating other policy to align with industry standards.

The agency also made housekeeping changes such as cross references from Title 388 WAC to Title 182 WAC, medicaid to Washington apple health, and changing all references from department to agency.

Reasons Supporting Proposal: See Purpose above.

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

Statute Being Implemented: RCW 41.05.021; 3ESSB 5034 (section 213, chapter 4, Laws of 2013).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Wendy Barcus, P.O. Box 42716, Olympia, WA 98504-2716, (360) 725-1306; Implementation and Enforcement: Dianne Baum, P.O. Box 45506, Olympia, WA 98504-5506, (360) 725-1590.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The agency has analyzed the proposed rules and concludes they do not impose more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

February 3, 2014
Kevin M. Sullivan
Rules Coordinator

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

WAC 182-535-1050 Dental-related services—Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC ((~~388-500-0005~~)) apply to this chapter. The ((~~department~~)) medicaid agency also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the

CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services in targeted areas for medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC ((~~388-535-1300~~)) 182-535-1300 for specific information.

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Anterior" refers to teeth (maxillary and mandibular incisors and canines) and tissue in the front of the mouth. Permanent maxillary anterior teeth include teeth six, seven, eight, nine, ten, and eleven. Permanent mandibular anterior teeth include teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven. Primary maxillary anterior teeth include teeth C, D, E, F, G, and H. Primary mandibular anterior teeth include teeth M, N, O, P, Q, and R.

"Asymptomatic" means having or producing no symptoms.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means using the assistance of one additional dental professional staff to manage the behavior of a client to facilitate the delivery of dental treatment.

"By report" - A method of reimbursement 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~~)) agency's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Caries" means carious lesions or tooth decay through the enamel or decay of the root surface.

"Comprehensive oral evaluation" means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

"Conscious sedation" is a drug-induced depression of consciousness during which a client responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

"Core buildup" refers to building up of clinical crowns, including pins.

"Coronal" is the portion of a tooth that is covered by enamel.

"Coronal polishing" is a mechanical procedure limited to the removal of plaque and stain from exposed tooth surfaces.

"Crown" means a restoration covering or replacing part or the whole clinical crown of a tooth.

"Current dental terminology (CDT)" is a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)" is a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Decay" is a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" is a drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

"Dental general anesthesia" see **"general anesthesia."**

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Denturist" means a person licensed under chapter 18.30 RCW to make, construct, alter, reproduce, or repair a denture.

"Endodontic" means the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

"EPSDT" means the ((~~department's~~)) agency's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter ((~~388-534~~)) 182-534 WAC.

"Extraction" see **"simple extraction"** and **"surgical extraction."**

"Flowable composite" is a diluted resin-based composite dental restorative material that is used in cervical restorations and small, low stress bearing occlusal restorations.

"Fluoride varnish, rinse, foam or gel" is a substance containing dental fluoride which is applied to teeth.

"General anesthesia" is a drug-induced loss of consciousness during which a client is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"High noble metal" is a dental alloy containing at least sixty percent pure gold.

"Limited oral evaluation" is an evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

"Limited visual oral assessment" is an assessment by a dentist or dental hygienist to determine the need for fluoride treatment and/or when triage services are provided in settings other than dental offices or dental clinics.

"Major bone grafts" is a transplant of solid bone tissue(s).

"Medically necessary" see WAC ((~~388-500-0005~~)) 182-500-0070.

"Minor bone grafts" is a transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

"Noble metal" is a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Oral evaluation" see **"comprehensive oral evaluation."**

"Oral hygiene instruction" means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

"Oral prophylaxis" is the dental procedure of scaling and polishing which includes removal of calculus, plaque, and stains from teeth.

"Partials" or **"partial dentures"** are a removable prosthetic appliance that replaces missing teeth in one arch.

"Periodic oral evaluation" is an evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation.

"Periodontal maintenance" is a procedure performed for clients who have previously been treated for periodontal disease with surgical or nonsurgical treatment. It includes the removal of supragingival and subgingival microorganisms and deposits with hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Periodontal scaling and root planing" is a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation, an evaluation of periodontal conditions, and a complete periodontal charting as appropriate.

"Posterior" refers to the teeth (maxillary and mandibular premolars and molars) and tissue towards the back of the mouth. Permanent maxillary posterior teeth include teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen. Permanent mandibular posterior teeth include teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two. Primary maxillary posterior teeth include teeth A, B, I, and J. Primary mandibular posterior teeth include teeth K, L, S, and T.

"Proximal" is the surface of the tooth near or next to the adjacent tooth.

"Radiograph (X ray)" is an image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

"Reline" means to resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

"Root canal" is the chamber within the root of the tooth that contains the pulp.

"Root canal therapy" is the treatment of the pulp and associated periradicular conditions.

"Root planing" is a procedure to remove plaque, calculus, microorganisms, and rough cementum and dentin from tooth surfaces. This includes hand and mechanical instrumentation.

"Scaling" is a procedure to remove plaque, calculus, and stain deposits from tooth surfaces.

"Sealant" is a dental material applied to teeth to prevent dental caries.

"Simple extraction" is the routine removal of a tooth.

"Standard of care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

"Surgical extraction" is the removal of a tooth by cutting of the gingiva and bone. This includes soft tissue extractions, partial boney extractions, and complete boney extractions.

"Symptomatic" means having symptoms (e.g., pain, swelling, and infection).

"Temporomandibular joint dysfunction (TMJ/TMD)" is an abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

"Therapeutic pulpotomy" is the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges nonmedicaid customers for the same service or item. This is the maximum amount that the provider may bill the ((~~department~~)) agency.

"Wisdom teeth" are the third molars, teeth one, sixteen, seventeen, and thirty-two.

"Xerostomia" is a dryness of the mouth due to decreased saliva.

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

WAC 182-535-1060 Dental-related services—Client((~~s who are eligible for dental-related services~~)) eligibility. (((~~(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.~~)) (1) 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 bitewing 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.

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

WAC 182-535-1070 Dental-related services—Provider information. (1) The following providers are eligible to enroll with the ((~~medical assistance administration (MAA)~~)) medicaid agency to furnish and bill for dental-related services provided to eligible clients:

(a) Persons currently licensed by the state of Washington to:

(i) Practice dentistry or specialties of dentistry.

(ii) Practice as dental hygienists.

(iii) Practice as denturists.

(iv) Practice anesthesia by:

(A) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;

(B) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a certified registered nurse anesthetist (CRNA) under WAC 246-817-180; or

(C) Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the department of health (DOH) that is current at the time the billed service(s) is provided; or

(D) Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.

(v) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) Providing fluoride varnish under EPSDT.

(b) Facilities that are:

(i) Hospitals currently licensed by the DOH;

(ii) Federally qualified health centers (FQHCs);

(iii) Medicare-certified ambulatory surgical centers (ASCs);

(iv) Medicare-certified rural health clinics (RHCs); or

(v) Community health centers.

(c) Participating local health jurisdictions.

(d) Bordering city or out-of-state providers of dental-related services who are qualified in their states to provide these services.

(2) Subject to the restrictions and limitations in this section and other applicable WAC, ((~~MAA~~)) the agency pays licensed providers participating in the ((~~MAA~~)) agency's dental program for only those services that are within their scope of practice.

(3) For the dental specialty of oral and maxillofacial surgery((~~:~~

~~(a) MAA~~)), the agency requires a dentist to((~~:~~

~~(i) Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and~~

~~(ii)~~)) meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

(((~~(A) The dentist must have participated at least three years in a maxillofacial residency program; and~~

~~(B) The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.~~

~~(b) A dental provider who meets the requirements in (3)(a) of this section must bill claims using appropriate current dental terminology (CDT) codes or current procedural terminology (CPT) codes for services that are identified as covered in WAC and MAA's published billing instructions or~~

~~numbered memoranda.~~)) (a) The provider's professional organization guidelines;

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

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

(4) See WAC ((~~388-502-0020~~)) 182-502-0020 for provider documentation and record retention requirements. ((~~MAA~~)) The agency requires additional dental documentation under specific sections in this chapter and as required by DOH under chapter 246-817 WAC.

(5) See WAC ((~~388-502-0100 and 388-502-0150~~)) 182-502-0100 and 182-502-0150 for provider billing and payment requirements. Enrolled dental providers who do not meet the conditions in subsection (3)((~~(a)~~)) of this section must bill all claims using only the CDT codes for services that are identified in WAC and ((~~MAA's~~)) the agency's published billing instructions ((~~or numbered memoranda. MAA~~)) and provider notices. The agency does not reimburse for billed CPT codes when the dental provider does not meet the requirements in subsection (3)(a) of this section.

(6) See WAC ((~~388-502-0160~~)) 182-502-0160 for regulations concerning charges billed to clients.

(7) See WAC ((~~388-502-0230~~)) 182-502-0230 for provider payment reviews and ((~~appeal~~)) dispute rights.

(8) See chapter 182-502A WAC ((~~388-502-0240~~)) for provider audits and the audit appeal process.

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

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

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

(b) Are within the scope of an eligible client's ((~~medical care~~)) Washington apple health (WAH) program;

(c) Are medically necessary;

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

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

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

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

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

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

(2) For orthodontic services, see chapter 182-535A WAC.

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

(a) A client is not a client of the ((~~division of~~)) developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099;

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

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

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

((~~(3)~~)) (4) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

((~~(4)~~)) (5) Under the early periodic screening and diagnostic treatment (EPSDT) program, clients twenty years of age and younger may be eligible for dental-related services listed as noncovered.

((~~(5)~~)) (6) The agency evaluates a request for dental-related services that are:

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

(b) Listed as noncovered, according to WAC 182-501-0160.

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

WAC 182-535-1080 ((~~Covered~~)) Dental-related services—Covered—Diagnostic. Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and ((~~client-age~~)) client age requirements identified for a specific service.

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

~~(a)~~)) the following oral health evaluations and assessments((~~:~~

~~(b)~~)), per client, per provider or clinic:

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

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

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

(A) Specific dental problem or oral health complaint;

(B) Dental emergency; or

(C) Referral for other treatment.

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

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

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

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

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

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

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

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

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

(ii) Duplicate radiographs to be submitted:

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

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

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

(c) Covers an intraoral complete series once in a three-year period for clients fourteen years of age and older only if the agency has not paid for a panoramic radiograph for the same client in the same three-year period. The intraoral complete series includes at least fourteen ((~~through~~)) to twenty-two periapical and posterior bitewings. The agency limits reimbursement for all radiographs to a total payment of no more than payment for a complete series.

(d) Covers medically necessary periapical radiographs for diagnosis in conjunction with definitive treatment, such as root canal therapy. Documentation supporting medical necessity must be included in the client's record.

(e) Covers an occlusal intraoral radiograph once in a two-year period, for clients twenty years of age and younger.

(f) ((~~Covers oral facial photo images, only on a case-by-case basis when requested by the agency, for clients twenty years of age and younger.~~

(~~g~~))) Covers a maximum of four bitewing radiographs (((~~once per quadrant~~))) once every twelve months.

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

(((~~(i) May reimburse for panoramic radiographs for preoperative or postoperative surgery cases more than once in a three-year period, only on a case-by-case basis and when prior authorized, except when required by an oral surgeon.~~))) (h) Covers one preoperative and postoperative panoramic radiograph per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

(((~~(j)~~))) (i) Covers ((~~cephalometric films once in a two-year period for clients twenty years of age and younger, only on a case-by-case basis and when prior authorized~~)) one preoperative and postoperative cephalometric film per surgery without prior authorization. The agency considers additional radiographs on a case-by-case basis with prior authorization. For orthodontic services, see chapter 182-535A WAC.

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

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

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

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

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

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

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

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

WAC 182-535-1082 ((~~Covered~~)) Dental-related services—Covered—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

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

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.

(b) Is limited to once every:

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

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

(iii) Four months for a client residing in a nursing facility.

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

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

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

(iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in a nursing facility.

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

(e) Is covered for clients of the ((~~division of~~)) developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

(2) **Topical fluoride treatment.** The agency covers the following per client, per provider or clinic:

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

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

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

(d) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients ((~~from~~)) nineteen ((~~to sixty-four~~)) years of age and older, once within a twelve-month period.

(e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients ((~~sixty-five years of age and older~~)) who reside in alternate living facilities as defined in WAC 182-513-1301, up to three times within a twelve-month period.

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

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

(3) **Oral hygiene instruction.** Includes individualized instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. The agency covers oral hygiene instruction as follows:

(a) ((~~Oral hygiene instruction only~~)) For clients eight years of age and younger. For clients nine years of age and older, oral hygiene instruction is included as part of the global fee for oral prophylaxis.

(b) ((~~Oral hygiene instruction, no more than~~)) Once every six months, up to two times within a twelve-month period.

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

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

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

(4) **Tobacco cessation counseling for the control and prevention of oral disease.** The agency covers tobacco cessation counseling for pregnant women only. See WAC 182-531-1720.

(5) **Sealants.** The agency covers:

(a) Sealants for clients ((~~eighteen~~)) twenty years of age and younger and clients any age of the ((~~division of~~)) developmental disabilities ((~~of any age~~)) administration of DSHS.

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

(c) Sealants once per tooth:

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

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

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

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

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

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

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

(g) Sealants are included in the agency's payment for occlusal restoration placed on the same day.

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

(((~~(5)~~))) (6) **Space maintenance.** The agency covers:

(a) ((~~Covers~~)) Fixed unilateral or fixed bilateral space maintainers ((~~for clients twelve years of age and younger~~)), including recementation, for missing primary molars A, B, I, J, K, L, S, and T, subject to the following:

(i) Only when there is evidence of pending permanent tooth eruption.

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

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

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

(b) ((~~Covers~~)) The removal of fixed space maintainers ((~~for clients eighteen years of age and younger~~)) when removed by a different provider. Allowed once per quadrant.

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

WAC 182-535-1084 ((~~Covered~~)) Dental-related services—Covered—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and ((~~client age~~)) client age requirements identified for a specific service.

(1) **Amalgam and resin restorations for primary and permanent teeth.** The agency considers:

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

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

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

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

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

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

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

(e) Reimburses proximal restorations that do not involve the incisal angle on anterior teeth as a two-surface restoration.

(f) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

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

(h) Does not pay for replacement restorations within a two-year period unless the restoration has an additional adjoining carious surface. The agency pays for the replacement restoration as one multisurface restoration per client, per provider or clinic. The client's record must include X rays and documentation supporting the medical necessity for the replacement restoration.

(3) **Additional limitations on restorations on primary teeth.** The agency covers:

(a) A maximum of two surfaces for a primary first molar. (See subsection (6) of this section for a primary first molar that requires a restoration with three or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(b) A maximum of three surfaces for a primary second molar. (See subsection (6) of this section for a primary posterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth.

(c) A maximum of three surfaces for a primary anterior tooth. (See subsection (6) of this section for a primary anterior tooth that requires a restoration with four or more surfaces.) The agency does not pay for additional restorations on the same tooth after three surfaces.

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

(4) **Additional limitations on restorations on permanent teeth.** The agency covers:

(a) ((~~(b)~~)) Two occlusal restorations for the upper molars on teeth one, two, three, fourteen, fifteen, and sixteen if, the restorations are anatomically separated by sound tooth structure.

((~~(c)~~)) (b) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen, and sixteen.

((~~(d)~~)) (c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(5) **Crowns.** The agency:

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

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

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

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

(i) Tooth and soft tissue preparation;

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

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

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

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

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

(viii) Local anesthesia.

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

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

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

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

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

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

(6) **Other restorative services.** The agency covers the following restorative services:

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

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and ((~~fabricated~~)) prefabricated resin crowns for primary anterior teeth once every three years only for clients twenty years of age and younger as follows:

(i) For ages twelve and younger without prior authorization if the tooth requires a four or more surface restoration; and

(ii) For ages thirteen to twenty with prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns, for primary posterior teeth once every three years without prior authorization if:

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

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

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns, for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every three years, for clients twenty years of age and younger, without prior authorization.

(e) Prefabricated stainless steel crowns for clients of the ((~~division of~~)) developmental disabilities administration of the department of social and health services (DSHS) without prior authorization according to WAC 182-535-1099.

(f) Core buildup, including pins, only on permanent teeth, only for clients twenty years of age and younger, and only allowed in conjunction with ((~~indirect~~)) crowns and when prior authorized ((~~at the same time as the crown prior authorization~~)). For indirect crowns, prior authorization must be obtained from the agency at the same time as the crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

(g) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients twenty years of age and younger, and only when in conjunction with a crown and when prior authorized.

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

WAC 182-535-1086 ((~~Covered~~)) Dental-related services—Covered—Endodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related endodontic services listed in this section, subject to coverage limitations, restrictions, and ((~~client age~~)) client age requirements identified for a specific service.

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

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

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

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

(3) **Endodontic treatment on primary teeth.** The agency((~~:~~

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

(4) **Endodontic treatment on permanent teeth.** The agency:

(a) Covers endodontic treatment for permanent anterior teeth for all clients.

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

(c) Considers the following included in endodontic treatment:

(i) Pulpectomy when part of root canal therapy;

(ii) All procedures necessary to complete treatment; and

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

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

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

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

((~~(e)~~)) (5) **Endodontic retreatment on permanent anterior teeth.** The agency:

(a) Covers endodontic retreatment for clients twenty years of age and younger when prior authorized.

((~~(f) The agency~~)) (b) Covers endodontic retreatment of permanent anterior teeth for clients twenty-one years of age and older when prior authorized.

(c) Considers endodontic retreatment to include:

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

(ii) Placement of new filling material; and

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

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

(i) Initial diagnostic evaluation;

(ii) Initial diagnostic radiographs; and

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

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

((~~(i) Covers~~)) (6) **Apexification/apicoestomy.** The agency covers:

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

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

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

WAC 182-535-1088 ((~~Covered~~)) Dental-related services—Covered—Periodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related periodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

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

(a) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) only on a case-by-case basis and when prior authorized and only for clients twenty years of age and younger; and

(b) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) for clients of the ((~~division of~~)) developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099.

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

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

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

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

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

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

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

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

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

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

(f) Covers periodontal scaling and root planing, one time per quadrant in a twelve-month period for clients residing in a nursing facility.

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

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

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

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

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

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

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

(c) Covers periodontal maintenance only if performed at least twelve calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

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

(e) Covers periodontal maintenance for clients residing in a nursing facility:

(i) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every six months.

(ii) Periodontal maintenance allowed six months after scaling or root planing.

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

WAC 182-535-1090 ((~~Covered~~)) Dental-related services—Covered—Prosthodontics (removable). Clients described in WAC 182-535-1060 are eligible to receive the prosthodontics (removable) and related services, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

(a) Requires prior authorization for all removable prosthodontic and prosthodontic-related procedures. Prior authorization requests must meet the criteria in WAC 182-535-1220. In addition, the agency requires the dental provider to submit:

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

(ii) A dental record which identifies:

(A) All missing teeth for both arches;

(B) Teeth that are to be extracted; and

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

(b) Covers complete dentures, as follows:

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

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

(iii) ((~~Replacement of an immediate denture with a complete denture is covered, if the complete denture is prior~~

~~authorized at least six months after the seat date of the immediate denture.~~

~~(iv)~~)) Complete dentures are limited to:

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

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

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

(((~~(vi)~~))) (v) The provider must obtain a signed Denture Agreement of Acceptance (((#)) HCA 13-809) form from the client at the conclusion of the final denture try-in for an agency-authorized complete denture. If the client abandons the complete denture after signing the agreement of acceptance, the agency will deny subsequent requests for the same type of dental prosthesis if the request occurs prior to the dates specified in this section. A copy of the signed agreement must be kept in the provider's files and be available upon request by the agency.

(c) Covers resin partial dentures, as follows:

(i) A partial denture is covered for anterior and posterior teeth when the partial denture meets the following agency coverage criteria.

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

(B) The client has established caries control;

(C) Only if one or more anterior teeth are missing or four or more posterior teeth are missing (excluding teeth one, two, fifteen, sixteen, seventeen, eighteen, thirty-one, and thirty-two). Pontics on an existing fixed bridge do not count as missing teeth;

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

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

(ii) Prior authorization is required for partial dentures.

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

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

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

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

(f) Requires a provider to submit the following with a prior authorization request for a removable ((~~prostheties~~)) partial or complete denture for a client residing in an alternate living facility (ALF) as defined in WAC ((~~388-513-1301~~)) 182-513-1301 or in a nursing facility as defined in WAC 182-500-0075:

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

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

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

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

(v) A completed copy of the Denture/Partial Appliance Request for Skilled Nursing Facility Client (HCA 13-788) form (((~~DSHS 13-788~~))) available from the agency's published billing instructions which can be downloaded from the agency's web site.

(g) Limits removable partial dentures to resin-based partial dentures for all clients residing in one of the facilities listed in (f) of this subsection.

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

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

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

(b) Repairs:

(i) To complete dentures, once in a twelve-month period. The cost of repairs cannot exceed the cost of the replacement denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

(ii) To partial dentures, once in a twelve-month period. The cost of the repairs cannot exceed the cost of the replacement partial denture. The agency covers additional repairs on a case-by-case basis and when prior authorized.

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

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

(e) Laboratory fees, subject to the following:

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

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

(A) Is not eligible at the time of delivery of the ((~~prosthesis~~)) partial or complete denture;

(B) Moves from the state;

(C) Cannot be located;

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

(E) Dies.

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

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

WAC 182-535-1092 ((Covered)) Dental-related services—Covered—Maxillofacial prosthetic services. Clients described in WAC 182-535-1060 are eligible to receive the maxillofacial prosthetic services listed in this section, subject to the following:

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

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

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

WAC 182-535-1094 ((Covered)) Dental-related services—Covered—Oral and maxillofacial surgery services. Clients described in WAC 182-535-1060 are eligible to receive the oral and maxillofacial surgery services listed in this section, subject to the coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

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

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

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

(i) Clients eight years of age and younger;

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

(iii) Clients any age of the ((division of)) developmental disabilities administration of the department of social and health services (DSHS).

(d) For site-of-service and oral surgery CPT codes that require prior authorization, the agency requires the dental provider to submit:

(i) Documentation used to determine medical appropriateness;

(ii) Cephalometric films;

(iii) Radiographs (X rays);

(iv) Photographs; and

(v) Written narrative/letter of medical necessity.

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

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

(ii) Appropriate radiographs;

(iii) Medical justification with diagnosis;

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

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

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

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

(f) Covers routine and surgical extractions. Prior authorization is required when the:

(i) Extractions of four or more teeth over a six-month period, per provider, results in the client becoming edentulous in the maxillary arch or mandibular arch; or

(ii) Tooth number is not able to be determined.

(g) ((Requires)) Covers unusual, complicated surgical extractions with prior authorization ((for unusual, complicated surgical extractions)).

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

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

(j) Covers debridement of a granuloma or cyst that is five millimeters or greater in diameter. The agency includes debridement of a granuloma or cyst that is less than five millimeters as part of the global fee for the extraction.

(k) Covers the following without prior authorization:

(i) Biopsy of soft oral tissue;

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

(l) Requires providers to keep all biopsy reports or findings in the client's dental record.

(m) Covers the following with prior authorization (photos or radiographs, as appropriate, must be submitted to the agency with the prior authorization request):

(i) Alveoloplasty ((for clients twenty years of age and younger only)) on a case-by-case basis ((and when prior authorized. The agency covers alveoplasty)) (only when not performed in conjunction with extractions).

(((n) Covers)) (ii) Surgical excision of soft tissue lesions only on a case-by-case basis ((and when prior authorized)).

(((o) Covers)) (iii) Only the following excisions of bone tissue in conjunction with placement of complete or partial dentures ((for clients twenty years of age and younger when prior authorized)):

(((i))) (A) Removal of lateral exostosis;

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

(((iii))) (C) Surgical reduction of ((soft tissue)) osseous tuberosity.

(iv) Surgical access of unerupted teeth for clients twenty years of age and younger.

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

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

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

(c) Frenuloplasty/frenulectomy for clients six years of age and younger without prior authorization.

(d) Frenuloplasty/frenulectomy for clients from seven to twelve years of age only on a case-by-case basis and when prior authorized. Photos must be submitted to the agency with the prior authorization request. Documentation supporting the medical necessity for the service must be in the client's record.

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

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

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

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

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

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

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

WAC 182-535-1098 ((~~Covered~~)) Dental-related services—Covered—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

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

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

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

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

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

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

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

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

(ii) For clients eight years of age and younger, and for clients any age of the ((~~division of~~)) developmental disabilities administration of the department of social and health services (DSHS), documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(iii) For clients from nine ((~~to~~)) through twenty years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094 (1)(b), deep sedation or general anesthesia services do not require prior authorization.

(iv) Prior authorization is not required for oral or parenteral conscious sedation for any dental service for clients twenty years of age and younger, and for clients any age of the ((~~division of~~)) developmental disabilities administration of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

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

(vi) A provider must bill anesthesia services using the CDT codes listed in the agency's current published billing instructions.

(d) Covers administration of nitrous oxide, once per day.

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

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

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

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

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

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

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

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

(2) **Professional visits.** The agency covers:

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

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

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

(3) **Drugs and/or medicaments (pharmaceuticals).** The agency covers drugs and/or medicaments ((~~only when used with parenteral conscious sedation, deep sedation, or~~

~~general anesthesia~~)), such as antibiotics, steroids, anti-inflammatories, or other therapeutic medications for clients twenty years of age and younger. The agency's dental program does not pay for oral sedation medications.

(4) **Miscellaneous services.** The agency covers:

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

(i) Clients eight years of age and younger;

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

(iii) Clients any age of the ((~~division of~~)) developmental disabilities administration of DSHS; ((~~and~~))

(iv) Clients diagnosed with autism; and

(v) Clients who reside in an alternate living facility (ALF) as defined in WAC ((~~388-513-1301~~)) 182-513-1301 or in a nursing facility as defined in WAC 182-500-0075.

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

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

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

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

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

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

(1) **Preventive services.**

(a) Periodic oral evaluations. The agency covers periodic oral evaluations up to three times in a twelve-month period.

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

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

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

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

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

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

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

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

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

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

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

~~(ii) Second molars when the decay involves four or more surfaces.~~)) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every two years only for clients twenty years of age and younger without prior authorization.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every two years for clients twenty years of age and younger without prior authorization if:

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

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

(iii) The tooth had a pulpotomy.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding one, sixteen, seventeen, and thirty-two once every two years without prior authorization for any age.

(3) **Periodontic services.**

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

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

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

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

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

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

(i) Periodontal scaling and root planing, one time per quadrant in a twelve-month period.

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

(iii) Periodontal maintenance allowed six months after scaling or root planing.

(iv) Full-mouth or quadrant debridement allowed once in a twelve-month period.

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

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

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

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

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

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

WAC 182-535-1100 Dental-related services—Not covered. (1) The agency does not cover the following:

(a) The dental-related services described in subsection (2) of this section unless the services are covered under the early periodic screening, diagnosis and treatment (EPSDT) program. ((See WAC 182-534-0100 for information about the EPSDT program.)) When EPSDT applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental.

(b) Any service specifically excluded by statute.

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

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

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

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

(A) Washington Administrative Code (WAC).

(B) The agency's current published documents.

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

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

(i) Detailed and extensive oral evaluations or reevaluations.

(ii) ((Extraoral radiographs.

(iii)) Posterior-anterior or lateral skull and facial bone survey films.

(((iv))) (iii) Any temporomandibular joint films.

(((v))) (iv) Tomographic surveys/3-D imaging.

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

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

(viii))) (v) Comprehensive periodontal evaluations.

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

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

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

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

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

(i) Nutritional counseling for control of dental disease.

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

(iii))) Removable space maintainers of any type.

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

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

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

(vii) Space maintainers, for clients nineteen years of age and older.

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

(ix))) (iv) Custom fluoride trays of any type.

(((x))) (v) Bleach trays.

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

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

(ii) Preventative restorations.

(iii) Labial veneer resin or porcelain laminate restorations.

(iv) Sedative fillings.

(v) Crowns and crown related services.

(A) Gold foil restorations.

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

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

(v) Preventive restorations.

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

(((vii))) (D) Permanent indirect crowns for ((molar)) posterior teeth.

(((viii))) (E) Permanent indirect crowns on permanent anterior teeth for clients fourteen years of age and younger.

(((ix))) (F) Temporary or provisional crowns (including ion crowns).

(((x) Labial veneer resin or porcelain laminate restorations.

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

(xii) Sedative fillings.

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

(xiv))) (G) Any type of coping.

(((xv))) (H) Crown repairs.

(((xvi))) (I) Crowns on teeth one, sixteen, seventeen, and thirty-two.

(vi) Polishing or recontouring restorations or overhang removal for any type of restoration.

(((xvii) Amalgam restorations of primary posterior teeth for clients sixteen years of age and older.

(xviii) Crowns on teeth one, sixteen, seventeen, and thirty-two.

(xix))) (vii) Any services other than extraction on supernumerary teeth.

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

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

(A) Endodontic therapy on permanent bicuspids;

(B) Any apexification/recalcification procedures; or

(C) Any apicoectomy/periradicular service.

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

(iii))) the following endodontic services:

(((A))) (i) Indirect or direct pulp caps.

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

(((C) Endodontic therapy on molar teeth.

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

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

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

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

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

(A) Gingival flap procedures.

(B) Clinical crown lengthening.

(C) Osseous surgery.

(D) Bone or soft tissue grafts.

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

(F) Guided tissue regeneration.

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

(H) Distal or proximal wedge procedures.

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

(A) Intracoronal or extracoronal provisional splinting.

(B) Full mouth or quadrant debridement (except for clients of the developmental disabilities administration).

(C) Localized delivery of chemotherapeutic agents.

(D) Any other type of nonsurgical periodontal service.

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

(i) Removable unilateral partial dentures.

(ii) ((Adjustments to any removable prosthesis.

(iii))) Any interim complete or partial dentures.

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

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

(((vi))) (v) Precision attachments.

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

(((viii))) (vii) Replacement of second or third molars for any removable prosthesis.

(((ix))) (viii) Immediate dentures.

(((x))) (ix) Cast-metal framework partial dentures.

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

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

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

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

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

(i) Fixed partial denture pontic.

(ii) Fixed partial denture retainer.

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

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

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

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

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

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

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

(iii) Vestibuloplasty.

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

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

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

(A) Local anesthesia as a separate procedure.

(B) Regional block anesthesia as a separate procedure.

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

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

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

(ii) ((~~General anesthesia for clients twenty-one years of age and older.~~

~~(iii) Oral or parenteral conscious sedation for clients twenty-one years of age and older.~~

~~(iv) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide for clients twenty-one years of age and older.~~

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

(A) Fabrication of an athletic mouthguard.

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

~~(C)~~)) Nightguards.

(((~~D~~))) (C) Occlusion analysis.

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

(((~~F~~))) (E) Enamel microabrasion.

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

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

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

(((~~J~~))) (I) Educational supplies.

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

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

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

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

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

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

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

(Q) Botox or derma-fillers.

(3) The agency does not cover the following dental-related services for clients twenty-one years of age and older:

(a) The following diagnostic services:

(i) Occlusal intraoral radiographs;

(ii) Diagnostic casts;

(iii) Sealants (for clients of the developmental disabilities administration, see WAC 182-535-1099);

(iv) Pulp vitality tests.

(b) The following restorative services:

(i) Prefabricated resin crowns;

(ii) Any type of core buildup, cast post and core, or prefabricated post and core.

(c) The following endodontic services:

(i) Endodontic treatment on permanent bicuspids or molar teeth;

(ii) Any apexification/recalcification procedures;

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

(d) The following adjunctive general services:

(i) Occlusal guards; and

(ii) Anesthesia as follows:

(A) General;

(B) Oral or parenteral conscious sedation; and

(C) Analgesia or anxiolysis as a separate procedure except for administration of nitrous oxide.

(4) The agency evaluates a request for any dental-related services listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

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

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

(2) The agency requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on ((~~DSHS form~~)) General Information for Authorization (HCA 13-835) form, available on the agency's web site.

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

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

(b) Study models;

(c) Photographs; and

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

(4) The agency may require second opinions and/or consultations by a licensed independent doctor of dental surgery (DDS)/doctor of dental medicine (DMD) before authorizing any procedure.

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

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

(a) Is covered by another agency program;

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

(c) Fails to meet the program criteria, limitations, or restrictions in this chapter.

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

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be age five and younger. Once enrolled in the ABCD program, eligible clients are covered until their sixth birthday.

(b) Clients eligible under one of the following medical assistance programs are eligible for the ABCD program:

(i) Categorically needy program (CNP);

(ii) Limited casualty program-medically needy program (LCP-MNP);

(iii) Children's health program; or

(iv) State children's health insurance program (SCHIP).

(c) ABCD program services for eligible clients enrolled in a managed care organization (MCO) plan are paid through the fee-for-service payment system.

(2) Health care providers and community service programs identify and refer eligible clients to the ABCD program. If enrolled, the client and an adult family member may receive:

(a) Oral health education;

(b) "Anticipatory guidance" (expectations of the client and the client's family members, including the importance of keeping appointments); and

(c) Assistance with transportation, interpreter services, and other issues related to dental services.

(3) The ((~~department~~)) agency pays enhanced fees only to ABCD-certified dentists and other ((~~department-approved~~)) agency-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:

(a) Family oral health education. An oral health education visit:

(i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic; and

(ii) Must include all of the following:

(A) "Lift the lip" training;

(B) Oral hygiene training;

(C) Risk assessment for early childhood caries;

(D) Dietary counseling;

(E) Discussion of fluoride supplements; and

(F) Documentation in the client's file or the client's designated adult member's (family member or other responsible adult) file to record the activities provided and duration of the oral education visit.

(b) Periodic oral evaluation, up to two visits per client, per calendar year, per provider or clinic;

(c) Topical application of fluoride varnish;

(d) Amalgam, resin, and glass ionomer restorations on primary teeth, as specified in the agency's current ((~~department-published~~)) published documents;

(e) Therapeutic pulpotomy;

(f) Prefabricated stainless steel crowns on primary teeth, as specified in the agency's current ((~~department-published~~)) published documents;

(g) Resin-based composite crowns on anterior primary teeth; and

(h) Other dental-related services, as specified in the agency's current ((~~department-published~~)) published documents.

(4) The client's file must show documentation of the ABCD program services provided.

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

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

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

(2) The agency sets maximum allowable fees for dental services as follows:

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

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

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

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

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

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

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

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

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

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

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

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

~~(5)~~)) The agency pays eligible providers listed in WAC 182-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the pro-

vider meets the criteria in this chapter and other applicable WAC.

(((~~6~~))) (4) Dental hygienists who have a contract with the agency are paid at the same rate as dentists who have a contract with the agency, for services allowed under the Dental Hygienist Practice Act.

(((~~7~~))) (5) Licensed denturists who have a contract with the agency are paid at the same rate as dentists who have a contract with the agency, for providing dentures and partials.

(((~~8~~))) (6) The agency makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(((~~9~~))) (7) The agency may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(((~~10~~))) (8) The agency does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in the agency's reimbursement for comprehensive oral evaluations or limited oral evaluations.

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

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

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

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

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

(5) The agency pays dental general anesthesia services for eligible clients as follows:

(a) The initial thirty minutes constitutes one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit.

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

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

(((~~6~~))) (7) Participating providers must bill a client according to WAC 182-502-0160, unless otherwise specified in this chapter.

(((~~7~~))) (8) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 182-535-1240 and 182-535-1290.

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

WAC 182-535-1550 Payment for dental care provided out-of-state. See WAC ((~~388-501-0180, 388-501-0182, and 388-501-0184~~)) 182-501-0180, 182-501-0182, and 182-501-0184 for services provided outside the state of Washington. See WAC ((~~388-501-0175~~)) 182-501-0175 for designated bordering cities.

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

WAC 182-535A-0010 ((~~Definitions for~~)) Orthodontic services—Definitions. The following definitions and those found in ((~~WAC 388-500-0005~~)) chapter 182-500 WAC apply to this chapter.

"Appliance placement" means the application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

"Cleft" means an opening or fissure involving the dentition and supporting structures, especially one occurring in utero. These can be:

(1) Cleft lip;

(2) Cleft palate (involving the roof of the mouth); or

(3) Facial clefts (e.g., macrostomia).

"Comprehensive full orthodontic treatment" means utilizing fixed orthodontic appliances for treatment of the permanent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

"Craniofacial team" means a cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated management, promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

"Dental dysplasia" means an abnormality in the development of the teeth.

"EPSDT" means the ((~~department's~~)) agency's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter ((~~388-534~~)) 182-534 WAC.

"Hemifacial microsomia" means a developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face appears smaller sized).

"Interceptive orthodontic treatment" means procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

"Limited transitional orthodontic treatment" means orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

"Malocclusion" means improper alignment of biting or chewing surfaces of upper and lower teeth.

"Maxillofacial" means relating to the jaws and face.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Orthodontics" means treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Orthodontist" means a dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the department of health.

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

WAC 182-535A-0020 ((~~Clients who are eligible for~~)) Orthodontic treatment and orthodontic services—Client eligibility. (1) Subject to the limitations of this chapter and the age restrictions listed in this section, the ((~~department~~)) medicaid agency covers medically necessary orthodontic treatment and orthodontic-related services for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate, ((~~as follows:~~

~~(a) Clients in the categorically needy program (CNP) and the medically needy program (MNP) may receive orthodontic treatment and orthodontic-related services through age twenty~~)) for eligible clients. Refer to WAC 182-501-0060 to see which Washington apple health programs include orthodontic services in their benefit package. Any orthodontic treatment plan that extends beyond the client's twenty-first birthday will not be approved by the ((~~department.~~

~~(b) Clients in the state children's health insurance program (CHIP) may receive orthodontic treatment and orthodontic-related services through age eighteen.~~

~~(c) Clients who are eligible for services under the EPSDT program may receive orthodontic treatment and orthodontic-related services under the provisions of WAC 388-534-0100~~)) agency.

(2) Eligible clients may receive the same orthodontic treatment and orthodontic-related services in recognized out-of-state bordering cities on the same basis as if provided in-state. See WAC ((~~388-501-0175~~)) 182-501-0175.

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

WAC 182-535A-0030 ((~~Providers of~~)) Orthodontic treatment and orthodontic-related services—Provider eligibility. The following provider types may furnish and be paid for providing covered orthodontic treatment and orthodontic-related services to eligible medical assistance clients:

(1) Orthodontists;

(2) Pediatric dentists;

(3) General dentists; and

(4) ((~~Department~~)) Agency recognized craniofacial teams or other orthodontic specialists approved by the ((~~department~~)) agency.

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

WAC 182-535A-0040 ((~~Covered and noncovered~~)) Orthodontic treatment and orthodontic-related services—Covered, noncovered, and limitations to coverage. (1) Subject to the limitations in this section and other applicable WAC, the ((~~department~~)) medicaid agency covers orthodontic treatment and orthodontic-related services for a client who has one of the medical conditions listed in (a) and (b) of this subsection. Treatment and follow-up care must be performed only by an orthodontist or ((~~department-recognized~~)) agency-recognized craniofacial team and do not require prior authorization.

(a) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement.

(b) The following craniofacial anomalies:

(((~~A~~))) (i) Hemifacial microsomia;

(((~~B~~))) (ii) Craniosynostosis syndromes;

(((~~C~~))) (iii) Cleidocranial dental dysplasia;

(((~~D~~))) (iv) Arthrogryposis; or

(((~~E~~))) (v) Marfan syndrome.

(2) Subject to prior authorization requirements and the limitations in this section and other applicable WAC, the ((~~department~~)) agency covers orthodontic treatment and orthodontic-related services for severe malocclusions with a Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score of twenty-five or higher.

(3) The ((~~department~~)) agency may cover orthodontic treatment for dental malocclusions other than those listed in subsection (1) and (2) of this section on a case-by-case basis and when prior authorized.

(4) The ((~~department~~)) agency does not cover the following orthodontic treatment or orthodontic-related services:

(a) Replacement of lost, or repair of broken, orthodontic appliances;

(b) Orthodontic treatment for cosmetic purposes;

(c) Orthodontic treatment that is not medically necessary (((~~see WAC 388-500-0005~~)) as defined in WAC 182-500-0070);

(d) Out-of-state orthodontic treatment, except as stated in WAC ((~~388-501-0180~~)) 182-501-0180 (see also WAC ((~~388-501-0175~~)) 182-501-0175 for medical care provided in bordering cities); or

(e) Orthodontic treatment and orthodontic-related services that do not meet the requirements of this section or other applicable WAC.

(5) The ((~~department~~)) agency covers the following orthodontic treatment and orthodontic-related services with prior authorization, subject to the limitations listed (providers must bill for these services according to WAC ((~~388-535A-0060~~)) 182-535A-0060):

(a) Panoramic radiographs (X rays) when medically necessary.

(b) Interceptive orthodontic treatment, ((~~once per a client's lifetime~~)) when medically necessary.

(c) Limited transitional orthodontic treatment, ((~~once per a client's lifetime~~)) when medically necessary. The treatment must be completed within twelve months of the date of the original appliance placement (see subsection (6)(a) of this section for information on limitation extensions). The agency's payment includes final records, photos, panoramic X rays, cephalometric films, and final trimmed study models.

(d) Comprehensive full orthodontic treatment ((~~once per a client's lifetime~~)), when medically necessary. The treatment must be completed within thirty months of the date of the original appliance placement (see subsection (6)(a) of this section for information on limitation extensions). The agency's payment includes final records, photos, panoramic X rays, cephalometric films, and final trimmed study models.

(e) Orthodontic appliance removal only when:

(i) The client's appliance was placed by a different provider or dental clinic; and

(ii) The provider has not furnished any other orthodontic treatment or orthodontic-related services to the client.

(f) Other medically necessary orthodontic treatment and orthodontic-related services as determined by the ((~~department~~)) agency.

(6) The treatment plan must indicate that the course of treatment will be completed prior to the client's twenty-first birthday.

(7) The treatment must meet industry standards and correct the medical issue. If treatment is discontinued prior to completion, clear documentation must be kept in the client's file why treatment was discontinued or not completed.

(8) The ((~~department~~)) agency evaluates a request for orthodontic treatment or orthodontic-related services:

(a) That are in excess of the limitations or restrictions listed in this section, according to WAC ((~~388-501-0169~~)) 182-501-0169; and

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

(((~~7~~))) (9) The ((~~department~~)) agency reviews requests for orthodontic treatment or orthodontic-related services for clients who are eligible for services under the EPSDT program according to the provisions of WAC ((~~388-534-0100~~)) 182-534-0100.

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

WAC 182-535A-0050 ((~~Authorization and prior authorization for~~)) Orthodontic treatment and orthodontic-related services—Authorization and prior authorization. (1) When the ((~~department~~)) medicaid agency authorizes an interceptive orthodontic treatment, limited orthodontic treatment, full orthodontic treatment, or orthodontic-related services for a client, including a client eligible for services under the EPSDT program, that authorization indicates only that the specific service is medically necessary; ((~~it~~)) authorization is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided.

(2) For orthodontic treatment of a client with cleft lip, cleft palate, or other craniofacial anomaly, prior authorization is not required if the client is being treated by ((~~a department-recognized~~)) an agency-recognized craniofacial team, or an orthodontic specialist who has been approved by the ((~~department~~)) agency to treat cleft lip, cleft palate, or other craniofacial anomalies.

(3) Subject to the conditions and limitations of this section and other applicable WAC, the ((~~department~~)) agency requires prior authorization for orthodontic treatment and/or orthodontic-related services for other dental malocclusions that are not listed in WAC ((~~388-535A-0040~~)) 182-535A-0040(1).

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

WAC 182-535A-0060 ((~~Payment for~~)) Orthodontic treatment and orthodontic-related services—Payment. (1) The ((~~department~~)) medicaid agency pays providers for furnishing covered orthodontic treatment and orthodontic-related services described in WAC ((~~388-535A-0040~~)) 182-535A-0040 according to this section and other applicable WAC.

(2) The ((~~department~~)) agency considers that a provider who furnishes covered orthodontic treatment and orthodontic-related services to an eligible client has accepted the ((~~department's~~)) agency's fees as published in the ((~~department's~~)) agency's fee schedules.

(3) **Interceptive orthodontic treatment.** The ((~~department~~)) agency pays for interceptive orthodontic treatment as follows:

(a) The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months.

(b) Treatment must be completed within twelve months of the date of appliance placement.

(4) **Limited transitional orthodontic treatment.** The ((~~department~~)) agency pays for limited transitional orthodontic treatment as follows:

(a) The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months. The provider must bill the ((~~department~~)) agency with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval during the treatment.

(c) Treatment must be completed within twelve months of the date of appliance placement. Treatment provided after one year from the date the appliance is placed requires a limitation extension. See WAC ((~~388-535A-0040~~)) 182-535A-0040(6).

(5) **Comprehensive full orthodontic treatment.** The ((~~department~~)) agency pays for comprehensive full orthodontic treatment as follows:

(a) The first six months of treatment starts the date the initial appliance is placed and includes active treatment for the first six months. The provider must bill the ((~~department~~)) agency with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement.

(c) Treatment must be completed ((~~with~~)) within thirty months of the date of appliance placement. Treatment provided after thirty months from the date the appliance is placed requires a limitation extension. See WAC ((~~388-535A-0040~~)) 182-535A-0040(6).

(6) Payment for orthodontic treatment and orthodontic-related services is based on the ((~~department's~~)) agency's published fee schedule.

(7) Orthodontic providers who are in ((~~department-designated~~)) agency-designated bordering cities must:

(a) Meet the licensure requirements of their state; and

(b) Meet the same criteria for payment as in-state providers, including the requirements to contract with the ((~~department~~)) agency.

(8) If the client's eligibility for orthodontic treatment under WAC ((~~388-535A-0020~~)) 182-535A-0020 ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility. The ((~~department~~)) agency does not pay for these services.

(9) The client is responsible for payment of any orthodontic service or treatment received during any period of ineligibility, even if the treatment was started when the client was eligible. The ((~~department~~)) agency does not pay for these services.

(10) See WAC ((~~388-502-0160 and 388-501-0200~~)) 182-502-0160 and 182-501-0200 for when a provider or a client is responsible to pay for a covered service.

WSR 14-04-093
WITHDRAWL OF PROPOSED RULES
GAMBLING COMMISSION
(By the Code Reviser's Office)
[Filed February 4, 2014, 8:08 a.m.]

WAC 230-03-061, proposed by the gambling commission in WSR 13-15-041, appearing in issue 13-15 of the Washington State Register, which was distributed on August 7, 2013, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 14-04-094
WITHDRAWL OF PROPOSED RULES
BUILDING CODE COUNCIL
(By the Code Reviser's Office)
[Filed February 4, 2014, 8:10 a.m.]

WAC 51-54A-0605, proposed by the building code council in WSR 13-15-162, appearing in issue 13-15 of the Washington State Register, which was distributed on August 7, 2013, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 14-04-095
WITHDRAWL OF PROPOSED RULES
BUILDING CODE COUNCIL
(By the Code Reviser's Office)
[Filed February 4, 2014, 8:12 a.m.]

WAC 51-51-0100, proposed by the building code council in WSR 13-15-163, appearing in issue 13-15 of the Washington State Register, which was distributed on August 7, 2013, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 14-04-096
WITHDRAWL OF PROPOSED RULES
BUILDING CODE COUNCIL
(By the Code Reviser's Office)
[Filed February 4, 2014, 8:17 a.m.]

WAC 51-54A-0908 and 51-54A-1103, proposed by the building code council in WSR 13-15-164, appearing in issue 13-15 of the Washington State Register, which was distributed on August 7, 2013, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 14-04-099
PROPOSED RULES
DEPARTMENT OF LABOR AND INDUSTRIES
[Filed February 4, 2014, 9:12 a.m.]

Continuance of WSR 14-01-088.

Expedited Rule Making-Proposed notice was filed as WSR 13-13-064.

Title of Rule and Other Identifying Information: eRules, chapter 296-829 WAC, Helicopters used as lifting machines; chapter 296-832 WAC, Late night retail worker crime prevention; chapter 296-876 WAC, Ladders, portable and fixed; and chapter 296-878 WAC, Window cleaning; SSB 5679.

Hearing Location(s): Department of Labor and Industries, 7273 Linderson Way S.W., Room S118, Tumwater, WA 98501, on March 11, 2014, at 9:00 a.m.

Date of Intended Adoption: April 22, 2014.

Submit Written Comments to: Catherine Julian, P.O. Box 44620, Olympia, WA 98504, e-mail catherine.julian@lni.wa.gov, fax (360) 902-5619, by 5:00 p.m., March 12, 2014.

Assistance for Persons with Disabilities: Contact Catherine Julian by March 3, 2014, (360) 902-5401 or catherine.julian@lni.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of this proposal is to add an additional public hearing, extending the public comment period from January 30, 2014, to March 12, 2014, due to an error regarding information posted on our web site regarding the public hearing that occurred on January 23, 2014.

Reasons Supporting Proposal: Stakeholders have complained that our rules on the web are confusing and difficult to access in real time. When the agency updated its web site, template DOSH rules in HTML were broken and DOSH began forwarding rule users to the office of the code reviser web site, which caused more confusion. This rule package will resolve stakeholder issues that have caused confusion for rule users by bringing one clear and consistent format to all of our rules.

Statutory Authority for Adoption: RCW 49.17.010, 49.17.040, 49.17.050, 49.17.060.

Statute Being Implemented: Chapter 49.17 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of labor and industries, governmental.

Name of Agency Personnel Responsible for Drafting: Jeff Killip, Tumwater, Washington, (360) 902-5530; Implementation and Enforcement: Anne Soiza, Tumwater, Washington, (360) 902-5090.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No change in requirements, so no economic impact.

A cost-benefit analysis is not required under RCW 34.05.328. No change in requirements, so no change in costs or benefits.

February 4, 2014
Joel Sacks
Director

WSR 14-04-100
PROPOSED RULES
DEPARTMENT OF AGRICULTURE
[Filed February 4, 2014, 9:34 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-22-093 and 14-01-025.

Title of Rule and Other Identifying Information: WAC 16-228-1231 What are state restricted use pesticides for distribution by licensed pesticide dealers and for use by certified applicators only? and 16-230-610 What are use restricted herbicides in Eastern Washington?

Hearing Location(s): Washington State Department of Agriculture, Second Floor Conference Room, Room 238, 21 North 1st Avenue, Yakima, WA 98902, on Wednesday, March 19, 2014, at 1:00 p.m.

Date of Intended Adoption: April 2, 2014.

Submit Written Comments to: Teresa Norman, P.O. Box 42560, Olympia, WA 98504-2560, e-mail WSDARulesComments@agr.wa.gov, fax (360) 902-2092, by March 19, 2014.

Assistance for Persons with Disabilities: Contact WSDA agency receptionist at (360) 902-1976, TTY (800) 833-6388 or 711 by March 5, 2014.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To exempt liquid formulations of ready-to-use phenoxy hormone-type herbicides from being declared state restricted use pesticides. Currently, salt formulations of phenoxy hormone-type herbicides distributed in quantities of one gallon or less and dry formulations intended only for home and garden use or turf use are exempt from being designated as state restricted use WAC 16-228-1231. The proposed amendment would add ready-to-use liquid formulations to the list of exempted products. The proposed amendments are a result of a petition for rule making submitted by The Scotts Company, LLC.

In addition, the amendment to WAC 16-230-610 will exempt liquid formulations of ready-to-use hormone-type herbicides from being declared use restricted herbicides in eastern Washington.

Reasons Supporting Proposal: Adopting rules exempting ready-to-use liquid formulations in quantities greater than one gallon would benefit human and environmental health. Ready-to-use liquid formulations are generally safer for the applicator since there is no mixing or loading involved and the percentage of active ingredient is generally much less than that found in a concentrate material. The potential for human exposure, and negative impacts from exposure if it should occur, are significantly reduced. It is also safer for the environment since it is less likely that product will be overapplied and less likely that there will be a need for disposal of unused product. Finally, it complies with the intent of the rule by significantly reducing the amount of active ingredient being purchased by an unlicensed person.

Statutory Authority for Adoption: RCW 15.58.040 and 17.21.030 and chapter 34.05 RCW.

Statute Being Implemented: RCW 15.58.040 and 17.21.-030.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: The Scotts Company, LLC, private.

Name of Agency Personnel Responsible for Drafting and Implementation: Cliff Weed, Olympia, Washington, (360) 902-2036; and Enforcement: Joel Kangiser, Olympia, Washington, (360) 902-2013.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The pesticide management division has analyzed the proposed rule amendment and the costs of compliance and has determined that the proposed

rule amendments impose no new costs on WSDA-regulated businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state department of agriculture is not a listed agency under RCW 34.05.328 (5)(a)(i).

January 29, 2014
Ted Maxwell
Assistant Director

AMENDATORY SECTION (Amending WSR 07-11-041A, filed 5/9/07, effective 6/9/07)

WAC 16-228-1231 What are state restricted use pesticides for distribution by licensed pesticide dealers and for use by certified applicators only? (1) Pesticides defined by the following categories or active ingredients are hereby declared state restricted use pesticides and shall be distributed only by licensed pesticide dealers to certified applicators or to their duly authorized agents. The certified applicator must have a valid certification, license or permit to use or purchase the kind and quantity of such pesticide sold or delivered. These pesticides shall be used or applied only by certified applicators or persons under the direct supervision of a certified applicator, and only for those uses covered by the certified applicator's license category.

(a) Any EPA restricted use pesticide.

(b) All formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba when distributed in counties located east of the crest of the Cascade Mountains except as listed below:

(i) Salt formulations, including amine and sodium, distributed in quantities of one gallon or less;

(ii) Dry formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba labeled and intended only for home and garden use or for turf;

(iii) Ready to use liquid formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba distributed in quantities of five gallons or less. For purposes of this subsection, ready to use means a pesticide that is applied directly from its original container consistent with label directions.

(c) Strychnine and its salts.

(d) Aquatic pesticides. All pesticides formulations labeled for application onto or into water to control pests on or in water except as provided in subsection (2) of this section.

(2) Pesticides which are not classified as EPA restricted use pesticides and which are labeled and intended only for the following aquatic uses shall be exempt from the requirements of this section:

(a) Swimming pools;

(b) Wholly impounded ornamental pools or fountains;

(c) Aquariums;

(d) Closed plumbing and sewage systems;

(e) Enclosed food processing systems;

(f) Air conditioners, humidifiers, and cooling towers;

(g) Industrial heat exchange, air washing and similar industrial systems;

(h) Disinfectants;

(i) Aquatic environments in states other than Washington;

(j) Animal pets;

(k) Use within wholly enclosed structures (with floors) or fumigation chambers. Greenhouses are not considered as wholly enclosed structures for the purposes of this section; and

(l) Home and garden control of mosquito larvae.

(3) Pesticides containing the following active ingredients and their isomers are declared state restricted use pesticides for the protection of groundwater except when labeled and intended only for home and garden use((-)):

Atrazine;

Bromacil;

((~~depa~~)) DCPA;

Disulfoton;

Diuron;

Hexazinone;

Metolachlor;

Metribuzin;

Picloram;

Prometon;

Simazine; and

Tebuthiuron.

(4) Distribution of pesticides bearing combined labeling of uses onto or into water plus nonaquatic general uses, may be made by licensed pesticide dealers to noncertified applicators if the dealer indicates on the sales slip or invoice that the purchaser of the pesticide agrees that it will not be applied into or onto water. If requested by the department, dealers shall furnish records on the sales of pesticides labeled for application onto or into water, whether sold for that use or not. Records shall include the name and address of the purchaser, the complete product name and EPA registration number of the pesticide and the amount purchased. Records shall be kept for seven years from the date of distribution.

(5) Certified applicators may designate authorized agent(s) for the purpose of purchasing or receiving restricted use pesticides by making previous arrangements with the pesticide dealer, or the authorized agent may provide written authorization by the certified applicator to the dealer at the time of purchase. At the time of purchase by an authorized agent the pesticide dealer shall require the certified applicator's name and license number and positive identification of the authorized agent.

(6) Pesticide dealers must positively identify unknown purchasers of restricted use pesticides. Positive identification may be annually at the time of verification of the certified applicator's license number or for each individual purchase if the applicator is unknown to the dealer. Dealers must verify the identification of unknown purchasers of restricted use pesticides for telephone or electronic purchases either by fax (photo identification) or at the time of delivery.

AMENDATORY SECTION (Amending WSR 07-11-041A, filed 5/9/07, effective 6/9/07)

WAC 16-230-610 What are use restricted herbicides in Eastern Washington? All formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba except as listed below are use restricted herbicides.

(1) Salt formulations, including amine and sodium, distributed in quantities of one gallon or less;

(2) Dry formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba labeled and intended only for home and garden use or for turf.

(3) Ready-to-use liquid formulations of phenoxy hormone-type herbicides (e.g., 2,4-D, 2,4-DB, 2,4-DP (dichlorprop), MCPA, MCPB, MCPP (mecoprop)) and dicamba distributed in quantities of five gallons or less. For purposes of this subsection, "ready-to-use" means a pesticide that is applied directly from its original container consistent with label directions.

WSR 14-04-113
PROPOSED RULES
STATE BOARD OF HEALTH
[Filed February 4, 2014, 1:06 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-20-099.

Title of Rule and Other Identifying Information: WAC 246-101-010 Definitions within the notifiable conditions regulations, proposed changes to the definitions of "assisted living facility," "elevated blood lead level," and "laboratory."

Hearing Location(s): Heathman Lodge, 7801 N.E. Greenwood Drive, Vancouver, WA 98662, on March 12, 2014, at 11:20 a.m.

Date of Intended Adoption: March 12, 2014.

Submit Written Comments to: Rad Cunningham, P.O. Box 47846, Olympia, WA 98504, e-mail http://www3.doh.wa.gov/policyreview/, fax (360) 236-3059, by March 5, 2014.

Assistance for Persons with Disabilities: Contact Ted Dale by March 5, 2014, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposed rule is to change the definition of "elevated blood lead level" for children and adults for consistency with the Centers for Disease Control and Prevention's (CDC) blood lead reference level for children and adults. The proposed rule also changes the term "boarding home" to "assisted living facility" consistent with SHB 2056, chapter 10, Laws of 2012, and clarifies the definition of "laboratory" by including a reference to chapter 246-338 WAC, Medical test site rules.

Reasons Supporting Proposal: In 2009 the CDC revised their guidance on adult lead levels down from 25 micrograms per deciliter (µg/dL) to 10 µg/dL. In 2012 the CDC revised their guidance on childhood lead levels down to a level of concern of 5 µg/dL. The proposed rules replace the existing levels in the notifiable conditions rules with these more protective CDC standards. The proposed rule also changes the term "boarding home" to "assisted living facility" consistent with SHB 2056, chapter 10, Laws of 2012, and clarifies the definition of "laboratory" by including a reference to chapter 246-338 WAC, Medical test site rules.

Statutory Authority for Adoption: RCW 43.20.050.

Statute Being Implemented: RCW 43.20.050.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health and state board of health, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Rad Cunningham, 243 Israel Road S.E., Tumwater, WA 98501, (360) 236-3359.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule would not impose more than minor costs on businesses in an industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Rad Cunningham, 243 Israel Road S.E., Tumwater, WA 98501, phone (360) 236-3359, fax (360) 236-3059, e-mail rad.cunningham@doh.wa.gov.

February 4, 2014
Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 11-02-065, filed 1/4/11, effective 2/4/11)

WAC 246-101-010 Definitions within the notifiable conditions regulations. The following definitions apply in the interpretation and enforcement of this chapter:

(1) "Associated death" means a death resulting directly or indirectly from the confirmed condition of influenza or varicella. There should be no period of complete recovery between the illness and death.

(2) "Blood lead level" means a measurement of lead content in whole blood.

(3) "Board" means the Washington state board of health.

(4) "Carrier" means a person harboring a specific infectious agent and serving as a potential source of infection to others.

(5) "Case" means a person, alive or dead, diagnosed with a particular disease or condition by a health care provider with diagnosis based on clinical or laboratory criteria or both.

(6) "Child day care facility" means an agency regularly providing care for a group of children for less than twenty-four hours a day and subject to licensing under chapter 74.15 RCW.

(7) "Condition notifiable within three business days" means a notifiable condition that must be reported to the local health officer or the department within three business days following date of diagnosis. For example, if a condition notifiable within three business days is diagnosed on a Friday afternoon, the report must be submitted by the following Wednesday.

(8) "Communicable disease" means a disease caused by an infectious agent that can be transmitted from one person,

animal, or object to another person by direct or indirect means including transmission through an intermediate host or vector, food, water, or air.

(9) "Contact" means a person exposed to an infected person, animal, or contaminated environment that may lead to infection.

(10) "Department" means the Washington state department of health.

(11) "Disease of suspected bioterrorism origin" means a disease caused by viruses, bacteria, fungi, or toxins from living organisms that are used to produce death or disease in humans, animals, or plants. Many of these diseases may have nonspecific presenting symptoms. The following situations could represent a possible bioterrorism event and should be reported immediately to the local health department:

(a) A single diagnosed or strongly suspected case of disease caused by an uncommon agent or a potential agent of bioterrorism occurring in a patient with no known risk factors;

(b) A cluster of patients presenting with a similar syndrome that includes unusual disease characteristics or unusually high morbidity or mortality without obvious etiology; or

(c) Unexplained increase in a common syndrome above seasonally expected levels.

(12) "Elevated blood lead level" means blood lead levels equal to or greater than ((~~25~~)) 10 micrograms per deciliter for persons aged fifteen years or older, or equal to or greater than ((~~10~~)) 5 micrograms per deciliter in children less than fifteen years of age.

(13) "Emerging condition with outbreak potential" means a newly identified condition with potential for person-to-person transmission.

(14) "Food service establishment" means a place, location, operation, site, or facility where food is manufactured, prepared, processed, packaged, dispensed, distributed, sold, served, or offered to the consumer regardless of whether or not compensation for food occurs.

(15) "Health care-associated infection" means an infection acquired in a health care facility.

(16) "Health care facility" means:

(a) Any ((~~boarding home~~)) assisted living facility licensed under chapter 18.20 RCW; birthing center licensed under chapter 18.46 RCW; nursing home licensed under chapter 18.51 RCW; hospital licensed under chapter 70.41 RCW; adult family home licensed under chapter 70.128 RCW; ambulatory surgical facility licensed under chapter 70.230 RCW; or private establishment licensed under chapter 71.12 RCW;

(b) Clinics, or other settings where one or more health care providers practice; and

(c) In reference to a sexually transmitted disease, other settings as defined in chapter 70.24 RCW.

(17) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care who is:

(a) Licensed or certified in this state under Title 18 RCW; or

(b) Military personnel providing health care within the state regardless of licensure.

(18) "Health care services to the patient" means treatment, consultation, or intervention for patient care.

(19) "Health carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

(20) "HIV testing" means conducting a laboratory test or sequence of tests to detect the human immunodeficiency virus (HIV) or antibodies to HIV performed in accordance with requirements to WAC 246-100-207. To assure that the protection, including, but not limited to, pre- and post-test counseling, consent, and confidentiality afforded to HIV testing as described in chapter 246-100 WAC also applies to the enumeration of CD4 + (T4) lymphocyte counts (CD4 + counts) and CD4 + (T4) percents of total lymphocytes (CD4 + percents) when used to diagnose HIV infection, CD4 + counts and CD4 + percents will be presumed HIV testing except when shown by clear and convincing evidence to be for use in the following circumstances:

(a) Monitoring previously diagnosed infection with HIV;

(b) Monitoring organ or bone marrow transplants;

(c) Monitoring chemotherapy;

(d) Medical research; or

(e) Diagnosis or monitoring of congenital immunodeficiency states or autoimmune states not related to HIV.

The burden of proving the existence of one or more of the circumstances identified in (a) through (e) of this subsection shall be on the person asserting the existence.

(21) "Immediately notifiable condition" means a notifiable condition of urgent public health importance, a case or suspected case of which must be reported to the local health officer or the department without delay at the time of diagnosis or suspected diagnosis, twenty-four hours a day, seven days a week.

(22) "Infection control measures" means the management of infected persons, or of a person suspected to be infected, and others in a manner to prevent transmission of the infectious agent.

(23) "Institutional review board" means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects as defined in RCW 70.02.010.

(24) "Isolation" means the separation or restriction of activities of infected individuals, or of persons suspected to be infected, from other persons to prevent transmission of the infectious agent.

(25) "Laboratory" means any facility licensed as a medical test site under chapter 70.42 RCW and chapter 246-338 WAC.

(26) "Laboratory director" means the director or manager, by whatever title known, having the administrative responsibility in any licensed medical test site.

(27) "Local health department" means the city, town, county, or district agency providing public health services to persons within the area, established under chapters 70.05, 70.08, and 70.46 RCW.

(28) "Local health officer" means the individual having been appointed under chapter 70.05 RCW as the health offi-

cer for the local health department, or having been appointed under chapter 70.08 RCW as the director of public health of a combined city-county health department.

(29) "Member of the general public" means any person present within the boundary of the state of Washington.

(30) "Monthly notifiable condition" means a notifiable condition which must be reported to the local health officer or the department within one month of diagnosis.

(31) "Notifiable condition" means a disease or condition of public health importance, a case of which, and for certain diseases, a suspected case of which, must be brought to the attention of the local health officer or the state health officer.

(32) "Other rare diseases of public health significance" means a disease or condition, of general or international public health concern, which is occasionally or not ordinarily seen in the state of Washington including, but not limited to, spotted fever rickettsiosis, babesiosis, tick paralysis, anaplasmosis, and other tick borne diseases. This also includes public health events of international concern and communicable diseases that would be of general public concern if detected in Washington.

(33) "Outbreak" means the occurrence of cases or suspected cases of a disease or condition in any area over a given period of time in excess of the expected number of cases.

(34) "Patient" means a case, suspected case, or contact.

(35) "Pesticide poisoning" means the disturbance of function, damage to structure, or illness in humans resulting from the inhalation, absorption, ingestion of, or contact with any pesticide.

(36) "Principal health care provider" means the attending health care provider recognized as primarily responsible for diagnosis or treatment of a patient, or in the absence of such, the health care provider initiating diagnostic testing or treatment for the patient.

(37) "Public health authorities" means local health departments, the state health department, and the department of labor and industries personnel charged with administering provisions of this chapter.

(38) "Quarantine" means the separation or restriction on activities of an individual having been exposed to or infected with an infectious agent, to prevent disease transmission.

(39) "School" means a facility for programs of education as defined in RCW 28A.210.070 (preschool and kindergarten through grade twelve).

(40) "Sexually transmitted disease (STD)" means a bacterial, viral, fungal, or parasitic disease or condition which is usually transmitted through sexual contact, including:

(a) Acute pelvic inflammatory disease;

(b) Chancroid;

(c) *Chlamydia trachomatis* infection;

(d) Genital and neonatal Herpes simplex;

(e) Genital human papilloma virus infection;

(f) Gonorrhea;

(g) Granuloma inguinale;

(h) Hepatitis B infection;

(i) Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS);

(j) Lymphogranuloma venereum;

(k) Nongonococcal urethritis (NGU); and

(l) Syphilis.

(41) "State health officer" means the person designated by the secretary of the department to serve as statewide health officer, or, in the absence of this designation, the person having primary responsibility for public health matters in the state.

(42) "Suspected case" means a person whose diagnosis is thought likely to be a particular disease or condition with suspected diagnosis based on signs and symptoms, laboratory evidence, or both.

(43) "Third-party payor" means an insurer regulated under Title 48 RCW authorized to transact business in this state or other jurisdiction including a health care service contractor and health maintenance organization, an employee welfare benefit plan, or a state or federal health benefit program as defined in RCW 70.02.010.

(44) "Unexplained critical illness or death" means cases of illness or death with infectious hallmarks but no known etiology, in previously healthy persons one to forty-nine years of age excluding those with chronic medical conditions (e.g., malignancy, diabetes, AIDS, cirrhosis).

(45) "Veterinarian" means an individual licensed and practicing under provisions of chapter 18.92 RCW, Veterinary medicine, surgery, and dentistry.

WSR 14-04-114
PROPOSED RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed February 4 2014 1:57 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-22-096 and 14-03-080.

Title of Rule and Other Identifying Information: WAC 182-537-0300 School-based health care services for children in special education—Client eligibility, 182-540-110 Kidney center services—Eligibility, 182-544-0100 Vision care—Eligible clients—Twenty years of age and younger, 182-545-200 Outpatient rehabilitation (occupational, physical, and speech therapies), 182-546-0150 Client eligibility for hospice care, 182-546-5300 Nonemergency transportation—Client eligibility, 182-551-1200 Client eligibility for hospice care, 182-551-2020 Home health services—Eligible clients, 182-552-0100 Respiratory care—Client eligibility, 182-553-300 Home infusion therapy/parental nutrition program—Client eligibility and assignment, and 182-554-300 Enteral nutrition—Client eligibility.

Hearing Location(s): Health Care Authority (HCA), Cherry Street Plaza Building, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504 (metered public parking is available street side around building. A map is available at http://www.hca.wa.gov/documents/directions_to_csp.pdf or directions can be obtained by calling (360) 725-1000), on March 11, 2014, at 10:00 a.m.

Date of Intended Adoption: Not sooner than March 12, 2014.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, delivery 626 8th

Avenue, Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, by 5:00 p.m. on March 11, 2014.

Assistance for Persons with Disabilities: Contact Kelly Richters by March 3, 2014, TTY (800) 848-5429 or (360) 725-1307 or e-mail kelly.richters@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA 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.

Reasons Supporting Proposal: See Purpose statement.

Statutory Authority for Adoption: RCW 41.05.021; Patient Protection and Affordable Care Act (Public Law 111-148).

Rule is necessary because of federal law, Patient Protection and Affordable Care Act (Public Law 111-148).

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Kevin Sullivan, P.O. Box 42716, Olympia, WA 98504-2716, (360) 725-1344; Implementation and Enforcement: Gail Kreiger, P.O. Box 45506, Olympia, WA 98504-5506, (360) 725-1681.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The joint administrative rules review committee has not requested the filing of a small business economic impact statement, and these rules do not impose a disproportionate cost impact on small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

February 4, 2014
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~~)) - (The agency 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 are 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~~)) is 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 outpatient 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~~)) provider notices;

(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~~)) provider notices; 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~~)) persons 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~~)) Persons 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~~)) Persons 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~~)) Persons 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~~)) Persons 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~~)) persons according to the agency's published medicaid provider guides and provider notices.

(4) ((~~Clients~~)) Persons 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~~)) persons with other insurance.

(6) The agency does not pay for ambulance services for jail inmates and persons living in a correctional facility, including persons in work-release status. 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, 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~~)) 182-546-5700.

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) program (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 assignment. (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~~)) persons 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~~)) persons 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) Clients~~))) (4) Persons 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~~)) person meets the limited circumstances in WAC ((~~388-554-500~~)) 182-554-500 (1)(d).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: OSPI, governmental.

Name of Agency Personnel Responsible for Drafting: Catherine Slagle, OSPI, (360) 725-6136; Implementation: JoLynn Berge, OSPI, (360) 725-6292; and Enforcement: Allan J. Jones, OSPI, (360) 725-6122.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These revisions only apply to public school districts.

A cost-benefit analysis is not required under RCW 34.05.328.

February 4, 2014
Randy Dorn
State Superintendent
of Public Instruction

WSR 14-04-116
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed February 4, 2014, 2:09 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-21-021.

Title of Rule and Other Identifying Information: Chapter 392-144 WAC, School bus driver qualifications.

Hearing Location(s): Office of Superintendent of Public Instruction (OSPI), 2nd Floor Conference Room, 600 South Washington Street, Olympia, WA 98504-7200, on March 25, 2014, at 11:00 a.m.

Date of Intended Adoption: March 25, 2014.

Submit Written Comments to: Allan J. Jones, Director, Student Transportation, P.O. Box 47200, Olympia, WA 98504-7200, e-mail allan.jones@k12.wa.us, by March 25, 2014.

Assistance for Persons with Disabilities: Contact Wanda Griffin by March 21, 2014, TTY (360) 664-3631 or (360) 725-6142.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: New definitions and revisions to the definitions sections have been made to provide clarification on a lapsed, suspended and revoked school bus driver's authorization. In addition, the reference to "serious behavorial problem" was replaced with "professional misconduct."

Minor changes were made to the initial and continuing requirements to be a school bus driver. The disqualifying conditions concerning speeding tickets was revised from "speeding 10 mph or more" to "speeding." The law enforcement agencies are not providing the department of licensing the details of how many miles over the speed limit a driver was cited for. Also added to this section "driving too fast for conditions."

Clarified the school districts' responsibility when obtaining a copy of the driving record when the school bus driver resides out of state.

Statutory Authority for Adoption: RCW 28A.160.210.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-005 Purpose and authority. (1) The purpose of this chapter is to set the minimum standards and qualifications for ((~~public~~)) school district or contracted employees ((~~and contractors~~)) operating school buses for the transportation of public school children.

(2) The authority for this chapter is RCW 28A.160.210.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-020 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Superintendent" means the Washington state superintendent of public instruction or designee.

(2) "School bus driver" means a person, who is employed by a school district including contracted drivers under WAC 392-144-040 (1) and (2) and as part of that employment or contract, operates a school bus as defined in WAC 392-143-010, or other motor vehicles for the regularly scheduled transportation of students between home and school. School buses shall be operated by authorized school bus drivers when transporting students. An authorized school bus driver may also transport students on field trips and other school related activities.

(((~~(2)~~))) (3) "A school bus driver's authorization" means an authorization issued by the superintendent ((~~of public instruction~~)) indicating that the person has met the requirements to operate a school bus or other motor vehicle for the purpose of transporting students to and from school routinely on scheduled routes and/or school activities. A school bus driver must ((~~be authorized~~)) have a valid authorization prior to transporting students and such authorization shall continue in effect as long as the person continues to meet the requirements of this chapter. A school bus driver authorization is not valid if suspended, revoked or lapsed.

(((~~(3) "~~))) (4) "A lapsed school bus driver's authorization" means the driver does not have a valid driver's license, current first-aid training, a current medical examiner's certificate (including any required intrastate medical waiver) or current

in-service training. A school bus driver shall not operate a school bus with passengers on board until they meet all requirements. There is no requirement for a lapse in authorization to be reported to the superintendent of public instruction.

(5) "A suspended school bus driver's authorization" means the superintendent has suspended the school bus driver's authorization for a specific period of time. The superintendent will not remove the driver from the district's list of authorized drivers. This action does not prevent the school district from taking independent actions to terminate the employment of the driver. In that case, the school district would remove the driver from the list of their authorized drivers.

(6) "A revoked school bus driver's authorization" means the superintendent has determined the school bus driver no longer meets the minimum requirements of this chapter and the driver's name is removed from the list of authorized drivers at the employing school districts. The driver will not be eligible to be an authorized school bus driver at any school district until the disqualifying conditions are no longer present. In those rare situations where the disqualifying conditions are particularly grievous including, but not limited to, crimes against children and falsification of records, the revocation may be permanent.

(7) An "authorized school bus driver ((~~instructor's authorization~~)) instructor" means an ((~~authorization issued~~)) individual authorized by the superintendent ((~~of public instruction to a person successfully completing the superintendent of public instruction approved school bus driver instructor course. This authorization qualifies a person to train and~~)) to verify the training of school bus drivers. ((~~This authorization shall lapse unless the holder successfully completes an annual school bus driver instructor's in-service course.~~

~~(4)~~)) (8) "School bus driver training course" means a course established by the superintendent ((~~of public instruction~~)) and taught or overseen by an authorized school bus driver instructor. This course shall be successfully completed by all applicants for a school bus driver's authorization.

(((~~5~~))) (9) "School bus driver annual in-service training ((~~course~~))" means ((~~an~~)) annual ((~~course~~)) training taught by an authorized school bus driver instructor. The content and minimum time requirements of such ((~~course~~)) training shall be annually determined by the superintendent ((~~of public instruction~~)) and shall be ((~~required to be~~)) completed no earlier than August 1st and no later than November 1st by all authorized school bus drivers.

(((~~6~~))) (10) "School bus driver instructor's course" means a training program ((~~authorized~~)) established by the superintendent ((~~of public instruction~~)) to qualify a person as a school bus driver instructor.

(((~~7~~))) (11) "School bus driver instructor's annual in-service ((~~course~~)) training" means ((~~an~~)) annual required ((~~course~~)) training, the content of which shall be determined by the superintendent ((~~of public instruction~~)). Successful completion of this course prevents the instructor's authorization from lapsing.

(((~~8) "Serious behavioral problem" includes, but is not limited to, conduct which indicates unfitness to carry out the responsibilities related to the occupation or job performance of transporting children, such as: Dishonesty; immorality; or misuse of alcohol, a controlled substance, or a prescription drug; or furnishing alcohol or controlled substances to a minor or student. It does not include the orderly exercise during off-duty hours of any rights guaranteed under the law to citizens generally, except where such conduct indicates a safety risk for the transportation of students.~~

~~(9)~~)) (12) "Professional misconduct" means a documented instance of an authorized school bus driver failing to comply with the provisions of this chapter, the provisions of chapter 392-145 WAC, or the provisions of chapter 46.61 RCW while operating a school bus.

(13) "Medical examiner's certificate" means a written verification of passing a medical examination in accordance with the standards established in 49 C.F.R. 391.41 through 391.49, of the Federal Motor Carrier Safety Regulations.

(a) School bus drivers must provide verification of passing a medical examination at a minimum of every twenty-four months.

(b) School bus drivers must continue to meet these medical requirements during the time between examinations.

(c) A school district may require more frequent examinations of any school bus driver. If a school district requires a school bus driver to be examined by a district selected physician, the school district must pay for the cost of such exam. If the driver objects to the district selected physician, a physician must be selected that is mutually acceptable.

(d) An individual who is a diabetic being treated with insulin may hold a school bus driver authorization if they meet the following requirements:

(i) Possess a valid commercial driver license intrastate medical waiver for diabetes from the Washington state department of licensing or a valid interstate exemption certificate for diabetes issued by the Federal Motor Carrier Safety Administration;

(ii) Provide at a minimum of every twenty-four months to the authorizing school district(s) or employer a completed, signed copy of Form SPI 1643, Application Section, and a completed, signed copy of Form SPI 1643, Physician Evaluation Section indicating the driver's medical condition allows them to safely operate a school bus while using insulin. The Physician Evaluation Section must indicate that within the past three years, the driver has completed instruction including diabetes management and driving safety; the signs and symptoms of hypoglycemia and hyperglycemia, and what procedures must be followed if complications arise. Physician verification of participation in a diabetes education program covering these topics is required at least every three years in order to remain qualified for a school bus driver authorization;

(iii) Provide at a minimum of every twelve months to the authorizing school district(s) or employer a completed, signed copy of Form SPI 1643, Vision Evaluation Section indicating the driver does not have any vision problems that might impair safe driving;

(iv) Provide at a minimum of every six months to the authorizing school district(s) or employer a completed, signed copy of Form SPI 1643, HbA1c Report Section indicating values more than 5.9 and less than 9.6 (unless accompanied by the signed medical opinion that the event was inci-

dental and not an indication of failure to control glucose levels);

(v) Self-monitor blood glucose using an FDA approved device and demonstrate conformance with requirements (more than 100 mg/dl and less than 300 mg/dl):

(A) Within one hour before driving vehicles transporting students; and

(B) Approximately every four hours while on duty;

(vi) Maintain a daily log of all glucose test results for the previous six-month period and provide copies to the authorizing school district(s) or employer, and the medical examiner or physician upon request;

(vii) Carry a source of readily absorbable/fast-acting glucose while on duty;

(viii) Report immediately to their employer, any failure to comply with specific glucose level requirements as listed in (d)(iv) or (v) of this subsection, or loss of consciousness or control;

(ix) Individuals who have had a loss of consciousness or loss of control (cognitive function) due to a diabetic event do not qualify for a school bus driver authorization for one year, provided there has not been a recurrent hypoglycemic reaction requiring assistance of another person within the previous five years;

(x) A school bus driver is no longer authorized to operate a school bus and must be immediately removed from driving duties for any of the following:

(A) Results of the most recent HbA1c test indicating values less than 6.0 or greater than 9.5 unless accompanied by the signed medical opinion that the event was incidental and not an indication of failure to control glucose levels;

(B) Results of self-monitoring indicate glucose levels less than 100 mg/dl or greater than 300 mg/dl, until self-monitoring indicates compliance with specifications;

(C) Experiencing a loss of consciousness or control relating to diabetic condition;

(D) Failing to maintain or falsifying the required records, including self-monitoring records and any section of Form SPI 1643;

(xi) The authorizing school district or employer may request medical review of any or all signed, completed sections of Form SPI 1643, Washington State Authorized School Bus Driver Diabetes Exemption Program, and the driver's daily glucose test logs by a medical examiner or physician of their choice. The cost of this review shall be paid by the school district or employer.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-030 Training and qualifications of school bus driver instructors—Administration. The superintendent ((~~of public instruction~~)) shall determine the qualifications necessary for applicants for the school bus driver instructor course and qualifications necessary for continuation of the school bus driver instructor authorization. Each school bus driver instructor shall verify annually that they continue to meet ((~~said~~)) the qualifications. ((~~Intentional falsification of school bus driver training records shall result in permanent revocation of the school bus driver instructor authorization.~~)) In the case of denial of authorization or disqualification, the superintendent ((~~of public instruction~~)) shall provide an appeal process consistent with the provisions of this chapter.

(1) A school bus driver instructor's authorization shall lapse effective the first day of September of any school year, unless the driver instructor has successfully completed the school bus driver instructor's in-service training for that school year. A school bus driver instructor is not required to notify the superintendent when the instructor's authorization is lapsed. A school bus driver instructor with a lapsed authorization cannot verify the successful completion of the school bus driver training course or the school bus driver in-service training. Reinstatement of the school bus driver instructor's authorization that has lapsed for failure to complete the annual in-service training occurs automatically upon completion of the required training, provided the authorization has not expired.

(2) A school bus driver instructor's authorization shall expire effective the first day of September of the second school year without successful completion of the school bus driver instructor's annual in-service training. Reinstatement of a school bus driver instructor's authorization that has expired requires another successful completion of the school bus driver instructor training course. A school bus driver instructor with an expired authorization cannot verify the successful completion of the school bus driver training course or the school bus driver in-service training.

(3) Intentional falsification of school bus driver training records shall result in permanent revocation of the school bus driver instructor authorization. School bus driver training records include, but are not limited to:

(a) Initial school bus driver training records;

(b) School bus driver annual in-service training records;

(c) School bus driver annual verification reports as required by this chapter.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-040 Application to contractors. (1) Every contract between a school district and a ((~~private school bus~~)) contractor for ((~~pupil~~)) student transportation services shall provide for compliance with the requirements of this chapter and establish the responsibility of the contractor or school district, or both, to assure compliance with such requirements.

(2) Each driver employed by a ((~~private school bus~~)) contractor ((~~under contract with a school district~~)) to provide ((~~pupil~~)) student transportation services shall meet the requirements of this chapter, and shall be subject to the denial, suspension, lapse, and revocation of their school bus driver authorization and the authority to operate a motor vehicle under this chapter.

(((~~(3) Every contract between a school district and a charter bus carrier or excursion carrier, or subcontracted carrier shall require a carrier profile report indicating a satisfactory rating from the Washington utilities and transportation commission before any service is provided. No driver under this subsection shall have unsupervised access to children. Super-~~

~~vision of children under this subsection shall be provided by a responsible employee of the school district.~~))

NEW SECTION

WAC 392-144-045 Use of charter bus companies. Every contract between a school district and a charter bus carrier or excursion carrier, or subcontracted carrier shall require a carrier profile report indicating a satisfactory rating from the Washington utilities and transportation commission before any service is provided. Supervision of children on trips under this subsection shall be designated to a specific employee of the school district who shall ensure that the driver shall have not have unsupervised access to students during the trip.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-101 Initial requirements for school bus drivers. Every authorized school bus driver must meet the following initial requirements:

(1) ((~~Be at least twenty-one years of age.~~

~~(2)~~)) Have at least ((~~one year of experience as a driver of a truck or commercial vehicle requiring a special endorsement or, in the alternative, at least three~~)) five years of experience as a licensed driver of a passenger vehicle.

(((~~(3)~~))) (2) Submit to a criminal record check according to chapter 28A.400 RCW which shows that no offenses have been committed which would be grounds for ((~~denial~~)) disqualification of an authorization as listed in WAC 392-144-103.

(((~~(4)~~))) (3) Satisfactorily complete a school bus driver training course administered by an authorized school bus driver instructor.

(((~~(5)~~))) (4) Meet all applicable continuing school bus driver requirements in WAC 392-144-102.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-102 Continuing requirements for authorized school bus drivers. Every authorized school bus driver must continue to meet the following requirements:

(1) Have a valid driver's license or commercial driver's license, as required by law, issued by the state department of licensing.

(2) Satisfactorily complete the annual school bus driver in-service training course.

(3) ((~~Hold a~~)) Maintain current and valid training in a first-aid ((~~card which certifies that the applicant has completed a~~)) course ((~~in first aid~~)) accepted by the local school district.

(4) Submit annually to the school district a disclosure of all crimes against children or other persons and all civil adjudications in a dependency action or in a domestic relation action and all disciplinary board final decisions of sexual abuse or exploitation or physical abuse as required by RCW 43.43.834(2) and disclosure of all convictions which may be grounds for denial, suspension, or revocation of authorization under WAC 392-144-103.

(5) Every authorized school bus driver must continue to meet the following physical requirements:

(a) Is physically able to maneuver and control a school bus under all driving conditions; and

(b) Is physically able to use all controls and equipment found on state minimum specified school buses; and

(c) Is physically able to perform daily routine school bus vehicle safety inspections; and

(d) Has sufficient strength and agility to move about in a school bus as required to provide assistance to students in evacuating the bus. The driver must be able to move from a seated position in a sixty-five passenger school bus, or the largest school bus the driver will be operating, to the emergency door, open the emergency door, and exit the bus through the emergency door, all within twenty-five seconds. A school district may develop and implement an alternative assessment of physical strength and agility. The alternate assessment must be submitted by the school district superintendent for review and approval by ((~~OSPI~~)) the superintendent; and

(e) Provide ((~~verification of holding~~)) a copy of a current and valid medical examiner's certificate to their employer.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-103 Disqualifying conditions for authorized school bus drivers. A school bus driver's authorization will be denied, suspended, or revoked as a result of the following conditions:

(1) Misrepresenting or concealing a material fact in obtaining or maintaining a school bus driver's authorization or in reinstatement thereof in the previous five years.

(2) Having a driving license privilege suspended or revoked as a result of a moving violation as defined in WAC 308-104-160 within the preceding five years or having had their commercial driver's license disqualified, suspended, or revoked within the preceding five years; a certified copy of the disqualification, suspension, or revocation order issued by the department of licensing being conclusive evidence of the disqualification, suspension, or revocation.

(3) Having been convicted of ((~~three or more speeding tickets of ten miles per hour or more over the speed limit~~)) any of the following motor vehicle violations within the last five years:

(a) Three or more speeding tickets, including driving too fast for conditions;

(b) Hit and run driving;

(c) Vehicular assault;

(d) Vehicular homicide;

(e) Driving while intoxicated;

(f) Being in physical control of motor vehicle while intoxicated;

(g) Negligent driving in the first degree;

(h) Any motor vehicle violation agreed to during a court proceeding as a result of an alcohol related driving infraction.

(4) Having intentionally and knowingly transported public school students within the state of Washington within the previous five years with a lapsed, suspended, surrendered, or

revoked school bus driver's authorization in a position for which authorization is required under this chapter.

(5) Having intentionally and knowingly transported public school students within the state of Washington within the previous five years with a suspended or revoked driver's license or a suspended, invalid, disqualified, or revoked commercial driver's license.

(6) Having refused to take a drug or alcohol test ((~~as required by~~)) in accordance with the provisions of 49 C.F.R. 382 within the preceding five years. ((~~Provided, That this requirement shall not apply to any refusal to take a drug or alcohol test prior to January 31, 2005.~~

~~(7) Having a serious behavioral problem which endangers the educational welfare or personal safety of students, teachers, school bus drivers, or other coworkers.~~

~~(8)~~)) (7) Having been convicted of any misdemeanor, gross misdemeanor, or felony (including instances in which a plea of guilty or *nolo contendere* is the basis for the conviction) or being under a deferred prosecution under chapter 10.05 RCW where the conduct or alleged conduct is related to the occupation of a school bus driver, including, but not limited to, the following:

(a) The physical neglect of a child under chapter 9A.42 RCW;

(b) The physical injury or death of a child under chapter 9A.32 or 9A.36 RCW, excepting motor vehicle violations under chapter 46.61 RCW;

(c) The sexual exploitation of a child under chapter 9.68A RCW;

(d) Sexual offenses where a child is the victim under chapter 9A.44 RCW;

(e) The promotion of prostitution of a child under chapter 9A.88 RCW;

(f) The sale or purchase of a child under RCW 9A.64.-030;

(g) Any crime involving the use, sale, possession, or transportation of any controlled substance or prescription drug within the last ten years;

(h) ((~~Any crime involving driving when a driver's license is suspended or revoked, hit and run driving, driving while intoxicated, being in physical control of motor vehicle while intoxicated, reckless driving, negligent driving of a serious nature, vehicular assault or vehicular homicide, within the last five years;~~

~~(i)~~)) Provided, That the general classes of felony crimes referenced within this subsection shall include equivalent federal crimes and crimes committed in other states;

((~~(j)~~)) (i) Provided further, That for the purpose of this subsection "child" means a minor as defined by the applicable state or federal law;

((~~(k)~~)) (j) Provided further, That for the purpose of this subsection "conviction" shall include a guilty plea.

((~~(9)~~)) (8) Having been convicted of any crime within the last ten years, including motor vehicle violations, which would materially and substantially impair the individual's worthiness and ability to serve as an authorized school bus driver. In determining whether a particular conviction would materially and substantially impair the individual's worthiness and ability to serve as an authorized school bus driver, the following and any other relevant considerations shall be weighed:

(a) Age and maturity at the time the criminal act was committed;

(b) The degree of culpability required for conviction of the crime and any mitigating factors, including motive for commission of the crime;

(c) The classification of the criminal act and the seriousness of the actual and potential harm to persons or property;

(d) Criminal history and the likelihood that criminal conduct will be repeated;

(e) The permissibility of service as an authorized school bus driver within the terms of any parole or probation;

(f) Proximity or remoteness in time of the criminal conviction;

(g) Any evidence offered which would support good moral character and personal fitness;

(h) If this subsection is applied to a person currently authorized as a school bus driver in a suspension or revocation action, the effect on the school bus driving profession, including any chilling effect, shall be weighed; and

(i) In order to establish good moral character and personal fitness despite the criminal conviction, the applicant or authorized school bus driver has the duty to provide available evidence relative to the above considerations. The superintendent ((~~of public instruction~~)) has the right to gather and present additional evidence which may corroborate or negate that provided by the applicant or authorized school bus driver.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-110 Temporary authorizations—Requirements and issuing procedures. (1) A temporary school bus driver authorization may be issued by the superintendent ((~~of public instruction~~)) upon application by an authorized representative of the employing school district when the following has been provided:

(a) Verification of successful completion of the school bus driver training course.

(b) Verification that it has on file a copy of a current and valid medical examiner's certificate.

(c) Verification that it has on file an original, current and complete school bus driver's abstract, including departmental actions, of the applicant's employment and nonemployment driving record obtained from the department of licensing verifying compliance with all provisions of this chapter. The issue date of this abstract must be within sixty calendar days prior to the date the application is being submitted for temporary authorization.

(d) Verification that it has on file a disclosure statement in compliance with preemployment inquiry regulations in WAC 162-12-140, signed by the applicant, specifying all convictions which relate to fitness to perform the job of a school bus driver under WAC 392-144-103 and all crimes against children or other persons, that meets the requirements of RCW 43.43.834(2).

(e) Verification that it has requested a criminal record check as required under chapter 28A.400 RCW and the date of such request.

(f) ((~~Verification that it has on file an applicant's disclosure of all serious behavioral problems which explains the nature of all such problems and/or conditions, a listing of the names, addresses, and telephone numbers of all doctors, psychologists, psychiatrists, counselors, therapists, or other health care practitioners of any kind or hospitals, clinics, or other facilities who have examined and/or treated the applicant for such problems and/or conditions and dates of examinations, therapy, or treatment and the school district has determined that any reported serious behavioral problem does not endanger the education welfare or personal safety of students, teachers, bus drivers, or other colleagues.~~

(~~g~~))) Verification that the applicant complies with all of the requirements for authorized school bus drivers set forth in this chapter except for ((~~a~~)) first-aid ((~~card~~)) training in a first-aid course and/or the results of a criminal record check.

(2) Upon approval of the temporary authorization, notice will be provided to the employing school district.

(3) The temporary authorization shall be valid for a period of sixty calendar days. The temporary authorization may be renewed by approval of the superintendent ((~~of public instruction~~)) when the results of the criminal background check have not been received.

AMENDATORY SECTION (Amending WSR 07-13-067, filed 6/18/07, effective 7/19/07)

WAC 392-144-120 School bus driver authorization—Requirements and issuing procedures. A school bus driver authorization may be issued by the superintendent ((~~of public instruction~~)) upon application by an authorized representative of the employing school district subject to compliance with the following provisions:

(1) The employing school district shall forward to the superintendent ((~~of public instruction~~)) the following verifications relating to the applicant:

(a) Verification of successful completion of the school bus driver training course taught by an authorized school bus driver instructor.

(b) Verification that it has on file a copy of a current and valid medical examiner's certificate.

(c) Verification that it has on file an original, current and complete school bus driver's abstract, including departmental actions, of the applicant's employment and nonemployment driving record obtained from the department of licensing verifying compliance with all provisions of this chapter. For applicants that have an out-of-state license, the district is required to annually obtain a current driving record from the corresponding state. The issue date of this abstract must be within sixty calendar days prior to the date an application was submitted for temporary authorization. If no request for a temporary school bus authorization was submitted, the issue date must be within sixty calendar days prior to the date of application of the school bus driver authorization.

(d) Verification that the applicant has completed a current and valid first-aid ((~~card~~)) training course.

(e) Verification that it has on file a disclosure statement in compliance with preemployment inquiry regulations in WAC 162-12-140, signed by the applicant, specifying all convictions which relate to fitness to perform the job of a school bus driver under WAC 392-144-103 and all crimes against children or other persons, that meets the requirements of RCW 43.43.834(2).

(f) Verification that it has on file the results of a criminal record check as required under chapter 28A.400 RCW and that such results establish that the applicant has not committed any offense which constitutes grounds for denying, suspending, or revoking an authorization under this chapter and the date of such request.

(g) ((~~Verification that it has on file an applicant's disclosure of all serious behavioral problems which explains the nature of all such problems and/or conditions, a listing of the names, addresses, and telephone numbers of all doctors, psychologists, psychiatrists, counselors, therapists, or other health care practitioners of any kind or hospitals, clinics, or other facilities who have examined and/or treated the applicant for such problems and/or conditions and dates of examinations, therapy, or treatment and the school district has determined that any reported serious behavioral problem does not endanger the educational welfare or personal safety of students, teachers, school bus drivers, or other colleagues.~~

(~~h~~))) Verification that the applicant complies with all of the requirements for authorized school bus drivers set forth in this chapter.

(2) Upon approval of an application, the superintendent ((~~of public instruction~~)) shall issue a notice of school bus driver authorization to the employing school district.

(3) Subsequent authorizations for an individual driver with new or additional employing school districts must be issued from the superintendent ((~~of public instruction~~)) to such districts prior to the operation of any motor vehicle for the transportation of children.

(4) The superintendent ((~~of public instruction~~)) will provide each school district with a list of their authorized school bus drivers and each authorized school bus driver's status.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-130 Discipline—Grounds for denial, suspension, or revocation of authorization—Emergency suspension—Appeals—Adjudicative proceedings. (1) A request for an authorization may be denied or an authorization issued under this chapter may be suspended or revoked for failure to meet any of the minimum requirements set forth in WAC 392-144-101 and 392-144-102 or for disqualifying conditions set forth in WAC 392-144-103, established by a preponderance of the evidence.

(2) ((~~Conduct, which by a preponderance of the evidence, amounts to a serious behavioral problem~~)) Professional misconduct, which endangers the educational welfare or personal safety of students, teachers, school bus drivers, or other colleagues is grounds for denial, suspension, or revocation whether or not the conduct constitutes a crime. ((~~If the act constitutes a crime, conviction in a criminal proceeding~~)) The employing school district shall determine if the profes-

sional misconduct is ((~~not~~)) a condition precedent to denial, suspension, or revocation action. Upon ((~~such~~)) a conviction, however, the judgment and sentence is conclusive evidence at the ensuing hearing of the guilt of the authorized driver or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based.

(3)(a) Any person in a court-ordered treatment program for alcohol or other drug misuse shall have his or her authorization suspended until treatment is satisfactorily completed and the completion is confirmed by a state-approved alcohol or drug treatment program at which time the authorization will be reinstated.

(b) In all cases of deferred prosecution under chapter 10.05 RCW, the authorization shall be suspended until the court confirms successful completion of the court approved treatment program at which time the authorization will be reinstated.

(4) Emergency suspension. If the superintendent ((~~of public instruction~~)) finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, emergency suspension of an authorization may be ordered pending proceedings for revocation or other action. In such cases, the superintendent ((~~of public instruction~~)) shall expedite all due process actions as quickly as possible.

(5)(a) Appeals and adjudicative proceedings. Any person desiring to appeal a denial, suspension, or revocation of a school bus driver authorization may do so to the superintendent ((~~of public instruction~~)) or designee in accordance with the adjudicative proceedings in RCW 34.05.413 through 34.05.494, and the administrative practices and procedures of the superintendent ((~~of public instruction~~)) in chapter 392-101 WAC.

(b) The superintendent ((~~of public instruction~~)) may assign the adjudicative proceeding to the office of administrative hearings and may delegate final decision-making authority to the administrative law judge conducting the hearing.

(c) The superintendent ((~~of public instruction~~)) may appoint a person to review initial orders and to prepare and enter final agency orders in accordance with RCW 34.05.464.

(d) Any person who disagrees with the school district's determination of failure to meet any school bus driver authorization qualifications may request that the school district forward the pertinent records to the superintendent ((~~of public instruction~~)). After review or investigation, the superintendent ((~~of public instruction~~)) shall grant, deny, suspend, or revoke the authorization.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-140 School bus driver—Reporting. (1) Every person authorized under this chapter to operate a motor vehicle to transport children shall, within twenty calendar days, notify his or her employer in writing of the filing of any criminal charge involving conduct listed in WAC 392-144-103. The authorized driver shall also notify his or her employer of any disqualifying traffic convictions, or license suspension, disqualification, or revocation orders issued by the department of licensing. In cases where the employer is providing transportation services through a contract with the school district, the contractor shall immediately notify the school district superintendent or designee.

(2) The notification in writing shall identify the name of the authorized driver, his or her ((~~authorization~~)) driver's license number, the court in which the action is commenced, and the case number assigned to the action.

(3) The failure of an authorized driver to comply with the provisions of this section is an act of ((~~unprofessional conduct~~)) professional misconduct and constitutes grounds for authorization suspension or revocation by the superintendent ((~~of public instruction~~)).

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-150 School district—Reporting. (1) Every school district employing authorized school bus drivers to transport children or contracting with a private firm who provides such authorized drivers as a part of a contract shall, within twenty calendar days, notify the superintendent ((~~of public instruction~~)) in writing of knowledge it may have of any disqualifying ((~~traffic convictions~~)) conditions or the filing of any criminal charge involving the conduct listed in WAC 392-144-103 against any authorized school bus driver.

(2) The notification can be in writing ((~~shall be by certified~~)) or ((~~registered mail~~)) by e-mail to the superintendent or its designee and shall identify the name of the authorized school bus driver, his or her ((~~authorization~~)) driver's license number, the mailing address of the driver, the court in which the action is commenced, and the case number assigned to the action.

AMENDATORY SECTION (Amending WSR 08-19-017, filed 9/5/08, effective 10/6/08)

WAC 392-144-160 School district—Verification of driver's continuing compliance. (1) Every school district shall annually evaluate each authorized school bus driver for continuing compliance with the provisions of this chapter annually. The results of this evaluation of all drivers shall be ((~~included with the Annual Transportation Report~~)) submitted to the ((~~regional transportation coordinator on SPI Form 1799, School Bus Driver Compliance Report,~~)) superintendent or their designee no later than the last business day in October of each year.

(2) This ((~~report~~)) annual evaluation shall ((~~verify that each authorized school bus driver's medical examination certificate expiration date, first-aid expiration date, driver's license expiration date and most recent school bus driver in-service training date has been updated in compliance with OSPI procedures.~~

~~(3) This report shall verify that each authorized school bus driver has made an updated disclosure in writing and signed and sworn under penalty of perjury which updates the disclosure required in WAC 392-144-102(4).~~

~~(4) This report shall verify that a current and original school bus driver's abstract has been obtained from the department of licensing on each authorized school bus driver~~

~~and the driving record is in compliance with WAC 392-144-103.~~

~~(5) This report shall verify that each authorized school bus driver remains in compliance with the physical requirements of WAC 392-144-102(5).~~

~~(6) This report shall be a written verification that the evaluation has been conducted in accordance with the requirements of this chapter and that all drivers are in compliance, or if all drivers are not in compliance, a list of drivers who are out of compliance and the reason for noncompliance shall be provided.~~)) certify that the district has verified the following:

(a) That each authorized school bus driver's medical examination certificate expiration date, first-aid expiration date, driver's license expiration date and most recent school bus driver in-service training date has been updated in compliance with procedures established by the superintendent;

(b) That each authorized school bus driver has made an updated disclosure in writing and signed and sworn under penalty of perjury which updates the disclosure required in WAC 392-144-102(4); and

(c) That each authorized school bus driver remains in compliance with the physical requirements of WAC 392-144-102(5).

WSR 14-04-117
PROPOSED RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-27—Filed February 4, 2014, 3:24 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-24-109.

Title of Rule and Other Identifying Information: Plan management - filing deadline.

Hearing Location(s): Office of the Insurance Commissioner, Training Room (TR-120), 5000 Capitol Boulevard S.E., Tumwater, WA, on March 11, 2014, at 2:00 p.m.

Date of Intended Adoption: March 13, 2014.

Submit Written Comments to: Jason Siems, P.O. Box 40258, Olympia, WA 98504-0258, e-mail rulescoordinator@oic.wa.gov, fax (360) 586-3109, by March 10, 2014.

Assistance for Persons with Disabilities: Contact Lori [Lorie] Villaflores by March 10, 2014, TTY (360) 586-0241 or (360) 725-7087.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule will allow the commissioner to set filing deadlines to file with the commissioner rate and form filings for all individual health plans, small group health plans, and stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits. This will ensure that these plans are filed timely for review.

Reasons Supporting Proposal: Setting a filing deadline will require issuers to file timely and allow the agency to effectively manage the review and approval process of health benefit plans. In addition, the health benefit plans that must be sent to the health benefit exchange to be certified as qualified health plans will be sent to the health benefit exchange within consistent time frames.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.100, 48.43.340, 48.43.715, 48.44.050, 48.46.200.

Statute Being Implemented: RCW 48.18.100, 48.44.020, 48.46.060.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Siems, P.O. Box 40258, Olympia, WA 98504-0258, (360) 725-7037; Implementation: Molly Nollette, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7117; and Enforcement: AnnaLisa Gellermann, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7050.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The entities that must comply with the proposed rule are not small businesses, pursuant to chapter 19.85 RCW.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Jason Siems, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7037, fax (360) 586-3535, e-mail rulescoordinator@oic.wa.gov.

February 4, 2014
Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-170-870 Deadline for filing individual health plans, small group health plans, and stand-alone dental plans. This section applies to all individual health plans, small group health plans, and stand-alone dental plans that provide pediatric dental benefits as one of the essential health benefits. Each year, issuers must file with the commissioner a complete rate and form filing for the next calendar year on or before the deadline set by the commissioner. The commissioner must announce and post the filing deadline no later than March 31st of each year. Issuers will be permitted to amend filings only at the direction of the commissioner. Filings not timely submitted will be rejected without review.

WSR 14-04-127
PROPOSED RULES
DEPARTMENT OF FINANCIAL INSTITUTIONS
(Division of Credit Unions)

[Filed February 5, 2014, 9:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-22-084.

Title of Rule and Other Identifying Information: Credit Union Act, chapter 31.12 RCW. Propose and adopt rules to implement chapter 34, Laws of 2013 (SB 5302) regarding

frequency of board meetings. Chapter 208-400 WAC was created under Title 208 WAC.

Hearing Location(s): Department of Financial Institutions (DFI), 150 Israel Road S.W., Olympia, WA 98501, on March 20, 2014, at 2:00 p.m. - 4:00 p.m.

Date of Intended Adoption: April 8, 2014.

Submit Written Comments to: Linda Jekel, 150 Israel Road S.W., P.O. Box 41200, Olympia, WA 98504-1200, e-mail linda.jekel@dfi.wa.gov, fax (877) 330-6870, by Friday, March 28, 2014.

Assistance for Persons with Disabilities: Contact Linda Jekel by Friday, March 28, 2014, TTY (360) 664-8126 or (360) 902-8778.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: DFI wants to adopt rules to implement SB 5302 (chapter 34, Laws of 2013), addressing credit union corporate governance. These new rules will address frequency of board meetings.

Reasons Supporting Proposal: Specific information provided in the rules is necessary to guide the regulated industry in complying with the laws. These rules are proposed in compliance with OFM Guidance 3(a).

Statutory Authority for Adoption: RCW 31.12.516 and 31.12.365 (as passed legislature in 2013, section 6, chapter 34, Laws of 2013).

Statute Being Implemented: Chapter 31.12 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DFI, division of credit unions, governmental.

Name of Agency Personnel Responsible for Drafting: Catherine Mele-Hetter, 150 Israel Road S.W., Olympia, WA 98501, (360) 902-0515; Implementation and Enforcement: Linda Jekel, 150 Israel Road S.W., Olympia, WA 98501, (360) 902-8778.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The rule amendments will not impose more than minor costs on the businesses impacted by the proposed rules.

A cost-benefit analysis is not required under RCW 34.05.328. Not applicable to the proposed rules.

February 5, 2014
Linda Jekel, Director
Division of Credit Unions

NEW SECTION

WAC 208-400-020 Definitions. Unless the context clearly requires otherwise, as used in this chapter:

"Board" has the same meaning as ascribed in RCW 31.12.005(1).

"Board chair" means the serving chairperson of the board of directors of a credit union, who has been duly appointed by the board of directors to serve as its chair.

"CAMEL" means the rating system used to measure the safety and soundness of credit unions that are insured by the National Credit Union Share Insurance Fund (as defined in 12 U.S.C. Sec. 1783) and which scores a credit union's capital adequacy, asset quality, management, earnings, and asset/liability management (liquidity), both individually and on a composite basis.

"Credit union" has the same meaning as ascribed in RCW 31.12.005(5).

"Director" has the same meaning as ascribed to that term in RCW 31.12.005(8).

"Manager" means the duly appointed and serving chief executive officer of a credit union.

"Troubled condition" has the same meaning ascribed to that term in the rules of the National Credit Union Administration, at 12 C.F.R. Sec. 701.14 (b)(3).

"Unsafe or unsound practice" has the same definition as ascribed to that term in RCW 31.12.005(26).

NEW SECTION

WAC 208-400-030 Frequency of board meetings. (1) **Authority to determine the frequency of board of directors meetings.** Subject to the provisions of this section, a board may determine the frequency of its meetings and must specify such frequency in its bylaws.

(2) **Minimum meeting requirement.** A board of directors must meet a minimum of six times in each calendar year and at least once per calendar quarter.

(3) **Director's authority to require more frequent meetings.** The director may require that a board meet more frequently if he or she finds that it is necessary for the board to meet more frequently to address examination matters, including without limitation, evidence of any of the following:

(a) The credit union's current composite CAMEL rating issued by the director is a 3, 4, or 5;

(b) The credit union's current management component CAMEL rating issued by the director is a 3, 4, or 5;

(c) The credit union's net worth ratio is less than seven percent;

(d) The credit union is currently in a troubled condition;

(e) In the judgment of the director, the credit union has committed an unsafe or unsound practice that has not been corrected to the satisfaction of the director and that continues to be a concern to the director, or the credit union is about to commit an unsafe or unsound practice; or

(f) The credit union has been notified in writing by the director of a significant supervisory or financial concern.

(4) **Notification to the board.** If the director determines as set forth in subsection (3) of this section, that a board of directors must meet more frequently than as set forth in subsection (2) of this section, the director will send written notice to the board chair, with a copy to the credit union's manager, setting forth the director's findings underlying the determination and the required frequency of the board of directors' meetings. This notice will remain in effect until rescinded in writing by the director.

WSR 14-04-131
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed February 5, 2014, 10:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-24-059.

Title of Rule and Other Identifying Information: These rules address the details and methodology of the K-1 high poverty staffing compliance calculation as required by the legislature.

Hearing Location(s): Office of Superintendent of Public Instruction (OSPI), 600 Washington Street, Wanamaker Conference Room, Olympia, WA 98504, on March 25, 2014, at 10:00 a.m.

Date of Intended Adoption: March 25, 2014.

Submit Written Comments to: T. J. Kelly, P.O. Box 47200, Olympia, WA 98504, e-mail Thomas.Kelly@k12.wa.us, fax (360) 664-3683, by March 25, 2014.

Assistance for Persons with Disabilities: Contact Wanda Griffin by March 20, 2014, TTY (360) 664-3631 or (360) 725-6132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: These are new rules that are necessary to address the details and methodology for determining compliance with K-1 high poverty funding starting with the 2014-15 school year.

Reasons Supporting Proposal: To ensure that school districts are being funded in accordance with the Omnibus Appropriations Act.

Statutory Authority for Adoption: RCW 28A.150.290 and 84.52.0531.

Rule is not necessitated by federal law, federal or state court decision.

Name of Agency Personnel Responsible for Drafting and Implementation: T. J. Kelly, OSPI, (360) 725-6301; and Enforcement: JoLynn Berge, OSPI, (360) 725-6292.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Not applicable.

A cost-benefit analysis is not required under RCW 34.05.328. The superintendent of public instruction is not subject to RCW 34.05.328 per subsection (5)(a)(1)[(i)]. Additionally, this rule is not a significant legislative rule per subsection (5)(c)(iii).

February 5, 2014
Randy Dorn
State Superintendent
of Public Instruction

NEW SECTION

WAC 392-140-921 K-1 high poverty class size compliance. The superintendent of public instruction shall determine which high poverty schools are eligible for enhanced funding for class size reduction per WAC 392-140-915. High poverty class size compliance will be measured at each eligible school independent of other eligible schools within a district. A demonstrated class size will be measured at each eligible school. That demonstrated class size will be converted to a funded class size, and a weighted average funded class size by district will be calculated and used for funding purposes.

Compliance calculations will be performed in January, March, and June of each school year. The most recent weighted average funded class size will be used for funding purposes. Districts will be funded based on their budgeted high poverty class size from September through December. Only districts with at least one high poverty eligible school may budget an enhanced class size.

NEW SECTION

WAC 392-140-923 K-1 high poverty class size—Enrollment. School level enrollment by grade at each of the high poverty eligible schools will be considered from the current school year October 1 CEDARS data inclusive of changes through the enrollment count day in January, March, and June. All students in ALE programs will be excluded from the compliance calculation. First grade and full day kindergarten students will be considered a 1.0 FTE, while half day kindergartners will be considered a 0.5 FTE.

NEW SECTION

WAC 392-140-932 K-1 high poverty class size—Teachers. The superintendent of public instruction shall include in the calculation of high poverty class size compliance those teachers reported on the S-275 at the eligible schools that are coded in programs 01 and 79 to grade group K or 1, and are reported in one of the following duty roots:

- Duty Root 31 – Elementary teacher
- Duty Root 33 – Other teacher
- Duty Root 52 – Substitute teacher
- Duty Root 63 – Contractor teacher

S-275 data as of the published apportionment cutoff dates in January, March, and June will be considered in the calculation.

Program 21 special education teachers coded to grade K or 1 at the eligible schools multiplied by the annual percentage of students in special education instruction used in determination of a district's 3121 revenue will be included.

Teachers coded to program 02 alternative learning experience shall be excluded.

NEW SECTION

WAC 392-140-933 K-1 demonstrated class size. Demonstrated class size at each school will be calculated by first dividing the total teachers for that school as described in WAC 392-140-932 by the funded planning time factor of 1.155. The result of that calculation will be divided into the calculated total of K-1 student FTE for that school, and shall be the demonstrated class size. Funded class size will equal the demonstrated class size to a maximum of 24.1 and a minimum of 20.3 students per teacher.

A weighted average of funded class sizes across all high poverty eligible schools will be calculated by multiplying eligible enrollment as defined in WAC 392-140-923 at each

school by the funded class size at each school. The results of that calculation for each school will be summed and divided by the total K-1 calculate enrollment at all eligible schools to arrive at a district wide weighted average funded class size. This weighted average funded class size will be used for funding purposes.