WSR 15-22-004
PROPOSED RULES
UNIVERSITY OF WASHINGTON
[Filed October 21, 2015, 3:16 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 14-16-085.

Title of Rule and Other Identifying Information: New section WAC 478-120-137 Supplementary provisions regarding sexual misconduct, to be included in chapter 478-120 WAC, Student conduct code for the University of Washington.

Hearing Location(s): Room 142, Gerberding Hall, University of Washington (UW), Seattle Campus, on February 17, 2016, at 12:00 noon.

Date of Intended Adoption: March 10, 2016.

Submit Written Comments to: Rebecca Goodwin Deardorff, UW, Rules Coordination Office, Box 351210, Seattle, WA 981950-1210 [98195-1210], e-mail rules@uw.edu, by February 17, 2016.

Assistance for Persons with Disabilities: Contact disability services office by February 5, 2016, TTY (206) 543-6452 or (206) 543-6450.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: UW's new section, WAC 478-120-137 Supplementary provisions regarding sexual misconduct, is necessary to comply with the amendments to the student assistance general provisions regulations issued under the Higher Education Act of 1965, as amended (HEA), to implement the changes made to the Clery Act by the Violence Against Women Reauthorization Act of 2013 (VAWA) (Pub. L. 113-4). These provisions are also necessary to comply with the state legislature's recent adoption of statutes and amendments related to campus sexual violence, chapter 92, Laws of 2015.

Reasons Supporting Proposal: This new section to chapter 478-120 WAC, Student conduct code for the University of Washington, confirms that UW prohibits sexual misconduct (sexual assault, sexual harassment, sexual exploitation, stalking, relationship or dating violence, and domestic violence); clearly defines sexual misconduct and "consent"; clarifies the steps under UW's disciplinary process that apply in cases involving an allegation of sexual misconduct; and makes clear that protective measures can be implemented following an allegation of sexual misconduct.

Statutory Authority for Adoption: RCW 28B.20.130.

Statute Being Implemented: RCW 28B.20.130 and chapter 92, Laws of 2015.

Rule is necessary because of federal law, amendments to the student assistance general provisions regulations issued under the Higher Education Act of 1965, as amended (HEA); and changes made to the Clery Act by the Violence Against Women Reauthorization Act of 2013 (VAWA) (Pub. L. 113-4).

Name of Proponent: UW, governmental.

Name of Agency Personnel Responsible for Drafting: Elizabeth Lewis, Director, Community Standards and Student Conduct, 447 Schmitz Hall, UW, Seattle Campus, (206) 685-6194; Implementation and Enforcement: Denzil Suite, Vice-President for Student Life, 101 Gerberding Hall, UW, Seattle Campus, (206) 543-4972; or Bjong Wolf Yeigh, Chancellor, UW Bothell, UW 1-260G, UW, Bothell Campus, (425) 352-5221; or Mark Pagano, Chancellor, UW Tacoma, GWP 312, UW, Tacoma Campus, (253) 692-5646.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These rules do not impose a disproportionate impact on small businesses or affect a school district under Title 28A RCW.

A cost-benefit analysis is not required under RCW 34.05.328. UW does not consider this rule making to be a significant legislative rule.

October 21, 2015
Rebecca Goodwin Deardorff
Director of Rules Coordination

NEW SECTION

WAC 478-120-137 Supplementary provisions regarding sexual misconduct. (1) By way of clarification only, it is hereby affirmed that sexual assault, sexual harassment, indecent exposure, sexual exploitation, stalking, domestic violence, and relationship violence all as defined herein (collectively "sexual misconduct") are prohibited conduct and any student who has engaged in sexual misconduct may be subject to the imposition of disciplinary sanctions as described in WAC 478-120-040.

(2) Notwithstanding any other provision of this conduct code, a student may be subject to disciplinary proceedings in connection with any allegation of sexual misconduct that occurs off campus if the university reasonably determines that a significant university interest is affected.

(3) Notwithstanding any other provision of this conduct code, "exceptional circumstances" shall be deemed to exist in all cases involving an allegation of sexual misconduct, and such cases shall be subject to the following supplementary provisions:

(a) The initiating officer will concurrently serve both the accused student and any complainant(s) with a copy of the initiating officer's initial order. For the purposes of this section, "complainant" means a student or another member of the university community who believes that an act of sexual misconduct has been committed against him or her in violation of this conduct code.

(b) Either a complainant or the accused student may appeal such initial order in accordance with WAC 478-120-075, and both the accused student and any complainant shall receive notice of any appeal and notice of any hearing before the faculty appeal board.

(c) If a timely appeal of an initial order issued by the initiating officer is submitted and a request for a formal hearing is made, the faculty appeal board shall conduct a formal hearing in accordance with WAC 478-120-100 and 478-120-115 and the following supplementary provisions shall apply:

(i) Both the accused student and any complainant will have the right to participate as a party in the hearing, including to be represented by counsel and/or be accompanied by an advisor, to call witnesses, to cross-examine witnesses, and to submit documentary evidence. A complainant (with or without counsel and/or an advisor) may attend the formal

hearing in its entirety, regardless of whether the complainant decides to participate as a party.

(ii) An accused student and the complainant may not ask questions of each other directly, but may submit written questions to the chair, who will ask any relevant and appropriate questions submitted by these parties. The chair has discretion to accept, reject, or rephrase any question submitted by the accused student or a complainant.

(iii) At the discretion of the chair, and where the rights of the parties will not be prejudiced thereby, all or part of any formal hearing, including the testimony of witnesses, may be conducted by telephone, video, or other electronic means.

(iv) Both the accused student and any complainant shall be concurrently served with all orders issued by the faculty appeal board.

(d) In any matter involving an allegation of sexual misconduct, any complainant shall have the same rights as the accused student to participate as a party in any administrative review under WAC 478-120-105, to appeal a faculty appeal board's initial order to the president of the university under WAC 478-120-125, to participate as a party in any appeal to the president, and to seek reconsideration of a final order under WAC 478-120-135. In the event that a complainant appeals in a timely manner an initial order, such order shall not become final until that appeal is resolved. Any notices or orders issued by the president shall be concurrently served on the accused student and any complainant(s).

(e) Except as otherwise provided in this section, matters involving allegations of sexual misconduct will be subject to all the other applicable provisions of this conduct code.

(4) For the purposes of this section, "sexual misconduct" includes sexual assault, sexual harassment, indecent exposure, sexual exploitation, stalking, domestic violence, and relationship violence, all as defined in subsections (5) through (11) of this section.

(5) For the purposes of this student conduct code "sexual assault" means any sexual contact with another person without (or that exceeds) that person's consent.

(a) For the purposes of this definition, "sexual contact" includes:

(i) Any touching of another person for the purpose of sexual gratification; or

(ii) Any penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ, of another person.

(b) For the purposes of this definition, "consent" means that at the time of and throughout the sexual contact, there are actual words or conduct indicating freely given agreement between the parties to engage in the sexual contact. A determination of whether consent had been given in connection with an incident of sexual contact shall take into account the following:

(i) Past consent does not imply future consent;

(ii) Consent given to one person does not imply consent given to another person;

(iii) Consent to one sexual act does not imply consent to other sexual acts;

(iv) Lack of resistance to sexual contact does not imply consent;

(v) Consent can be withdrawn at any time.

(c) Consent cannot be given by a person who, at the relevant time, cannot understand the facts, nature, extent, or implications of the sexual contact for any reason including, but not limited to, being asleep, unconscious, mentally or physically impaired due to an intellectual or other disability, or mentally or physically incapacitated due to the effects of drugs or alcohol. Indications that a person may be incapacitated by alcohol or drugs and therefore cannot grant consent include, but are not limited to, stumbling, falling down, an inability to stand or walk on their own, slurred speech or incoherent communication, an inability to focus their eyes or confusion about what is happening around them, blacking out, or vomiting. A failure to exhibit any of these behaviors does not necessarily mean that a person is capable of giving consent or is not incapacitated.

(d) Sexual contact is not consensual when force or coercion is threatened or used to gain acquiescence. Force includes the use of physical violence, physical force, threats, or intimidation to overcome resistance or gain agreement to sexual contact. Coercion includes using pressure, deception, or manipulation to cause someone to agree to sexual contact against his or her will, without the use of physical force. Pressure can mean verbal or emotional pressure.

(e) Sexual assault also includes sexual contact with a person who is under the statutory age of consent in accordance with chapter 9A.44 RCW.

(f) Use of alcohol or other drugs is not a valid defense to an allegation of sexual assault.

(6) For the purposes of this conduct code, "sexual harassment" means unwelcome language or conduct of a sexual nature that is sufficiently severe, persistent, or pervasive such that it could reasonably be expected to create an intimidating, hostile, or offensive environment, or has the purpose or effect of unreasonably interfering with a person's academic or work performance or a person's ability to participate in or benefit from the university's programs, services, opportunities, or activities.

(7) For purposes of this conduct code, "indecent exposure" means the exposure of a person's genitals or other private body parts when done in a place or manner in which such exposure is likely to cause affront or alarm, or is against generally accepted standards of decency. Breast feeding or expressing breast milk is not indecent exposure.

(8) For the purposes of this conduct code, "sexual exploitation" includes:

(a) Taking nonconsensual or abusive advantage of another for one's own sexual benefit, or for the sexual benefit of anyone other than the one being exploited;

(b) Compelling another by threat or force to engage in sexual conduct or activity;

(c) Transmitting, distributing, publishing, or threatening to transmit, distribute, or publish photos, video, or other recordings of a private and sexual nature where such transmission, publication, or distribution is without the consent of the subject(s) and is likely to cause emotional distress to the subject(s);

(d) Taking or making photographs, films, or digital images of the private body parts of another person without that person's consent;

(e) Causing or attempting to cause the impairment of another person to gain nonconsensual sexual advantage over that person;

(f) Prostituting another person;

(g) Knowingly allowing another to surreptitiously watch otherwise consensual sexual activity; or

(h) Taking, making, or directly transmitting nonconsensual video or audio recordings of sexual activity.

(9) For purposes of this conduct code, "stalking" means engaging in a course of conduct that would cause a reasonable person to fear for his or her safety or the safety of others or to suffer substantial emotional distress. "Course of conduct" means two or more acts including, but not limited to, acts in which the stalker directly, indirectly, or through third parties, by any action, method, device, or means (including electronic), follows, monitors, observes, surveils, threatens, or communicates to or about a person, or interferes with a person's property. "Substantial emotional distress" means significant mental suffering or anguish that may, but does not necessarily require medical or other professional treatment or counseling.

(10) For purposes of this conduct code, "domestic violence" means the infliction of physical harm, bodily injury, assault, or the fear of imminent physical harm, bodily injury or assault committed against a family or household member, including:

(a) A current or former spouse or intimate partner;

(b) A person with whom the person shares a child in common;

(c) A person with whom one is cohabitating or has cohabitated; or

(d) A person with whom one resides including a roommate, suitemate or housemate.

Domestic violence also includes sexual assault or stalking as defined herein of one family or household member by another family or household member.

(11) For the purposes of this conduct code, "relationship violence," also referred to as "dating violence," means violence, other than domestic violence as defined in subsection (10) of this section, committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim. The existence of such a relationship shall be determined based on the reporting party's statement and with consideration of the length of the relationship, the type of relationship, and the frequency of interaction between the persons involved in the relationship. For the purposes of this definition, relationship or dating violence includes, but is not limited to, sexual or physical abuse or the threat of such abuse.

(12) As in all proceedings under this conduct code, the applicable standard of proof in cases involving sexual misconduct shall be the "preponderance of evidence" standard. This means that, in order for a student to be held responsible for a violation, it must be shown, based on all of the evidence in the record, that it is more likely than not that the student engaged in an act or acts of misconduct. The burden of proof in any hearing rests with the party seeking to establish that the violation occurred.

(13) Following receipt of a report of alleged sexual misconduct, the university may implement interim protective measures including, but not limited to:

(a) A "no-contact directive" prohibiting direct or indirect contact, by any means, with a complainant, an accused student, a reporting student, other specified persons, and/or a specific student organization;

(b) Reassignment of or removal from on-campus housing; or

(c) Changes to class schedules, assignments, or tests.

Interim protective measures will remain in place until an initial order becomes final or a final order is issued. Implementation of any interim measure does not assume any determination of, or create any presumption regarding responsibility for a violation under the student conduct code.

WSR 15-22-007
PROPOSED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed October 22, 2015, 11:57 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 14-23-019.

Title of Rule and Other Identifying Information: Amends WAC 181-78A-264 to reduce the hours in the school day for the internship requirements for principal certification.

Hearing Location(s): Radisson Hotel, SeaTac Airport, 18118 International Boulevard, Seattle, WA 98188, on January 21, 2016, at 8:30.

Date of Intended Adoption: January 21, 2016.

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 January 14, 2015 [2016].

Assistance for Persons with Disabilities: Contact David Brenna by January 14, 2015 [2016], (360) 725-6238.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Clarifies the number of hours for the principal internship within the academic year, half of the four hundred forty hours to be during school days with staff and students present.

Reasons Supporting Proposal: Reduces confusion in the existing language.

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.

October 22, 2015
David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 14-23-068, filed 11/18/14, effective 12/19/14)

WAC 181-78A-264 Approval standard—Program design. (1) Conceptual framework.

(a) The conceptual framework establishes the shared vision for the unit's efforts in preparing educators to work effectively in P-12 schools.

(b) The conceptual framework:

(i) Provides coherence among curriculum, instruction, field experiences, clinical practice, candidate assessment, and program evaluation;

(ii) Establishes the philosophy, purpose, goals, and standards of the program or unit;

(iii) Reflects renewing commitment to current research and best practices; and

(iv) Supports the state's goals for P-12 student learning and program approval Standard V.

(2) Transition elements.

(a) Programs recruit, admit, retain, and transition candidates to the field who meet program goals and state standards.

(b) Learner expectations for program requirements, progression, and completion are identified, published, and accessible.

(c) Faculty regularly review recruitment and retention data for effectiveness of program.

(i) Programs create, implement and communicate a recruitment and retention plan in response to data.

(ii) Programs annually report the data, the plan, and proposed modifications to the professional educator advisory board and other stakeholder groups supporting the program's efforts.

(iii) Program completers meet the state and partner districts' goals for increasing underrepresented populations in the workplace.

(iv) Program completers hold endorsements in shortage content areas identified by workforce data of the state and region.

(3) Field experiences and clinical practice.

(a) The program(s) and its school partners design, implement, and evaluate field experiences and clinical practices.

(b) Field experiences are integrated throughout the preparation program.

(i) Field experiences provide opportunity to plan, practice and reflect on methods of instruction and differentiation;

(ii) Field experiences provide opportunities to work with diverse communities and populations, e.g., racial and ethnic, low socioeconomic, and English language learners;

(iii) Faculty supervision, including on-site visits, will be provided on an on-going basis.

(c) Mentors are instructional leaders identified collaboratively with the partner school of district.

(i) Mentors and principals are provided with a set of internship expectations;

(ii) Mentors receive or provide evidence of training on mentoring of adult learners;

(iii) Mentors must be fully certificated school personnel and have a minimum of three years of professional experience in the role they are supervising;

(iv) Effectiveness of mentor preparation and communication are reviewed annually by faculty.

(d) All Washington educator preparation programs operating field experiences in Washington state shall establish and maintain field placement agreements with all Washington school districts in which candidates are placed for field experiences leading to certification or endorsement under WAC 181-78A-125.

(e) Entry and exit criteria and a process for mitigating concerns during clinical practice are provided for candidates and the mentor.

(f) Requirements for specific educator preparation programs.

(i) Teacher programs.

(A) Programs shall administer the teacher performance assessment adopted by the professional educator standards board to all candidates in a residency certificate program.

(B) Clinical practice (defined as supervised planning, instruction, and reflection) for teacher candidates should consist of no less than four hundred fifty hours in classroom settings.

(ii) School counselor programs.

(A) Candidates complete a supervised internship in the schools that includes a minimum of four hundred hours of on the job professional service and one hour per week of individual supervision provided by the mentor.

(B) Prior to the internship, the candidate will complete a faculty supervised practicum (a distinctly defined clinical experience intended to enable the candidate to develop basic counseling skills and integrate professional knowledge).

(iii) School psychology programs.

(A) Candidates complete a supervised internship in the schools that includes a minimum of one thousand two hundred hours of on the job professional service and one hour per week of individual supervision provided by the mentor.

(B) Prior to the internship, the candidate will complete a faculty supervised practicum (a distinctly defined clinical experience intended to enable the candidate to develop basic school psychology skills and integrate professional knowledge).

(iv) Administrator programs.

(A) The internship for administrators shall take place in an education setting serving under the general supervision of a certificated practitioner who is performing in the role for which certification is sought.

(B) Components of the required internship shall include demonstration by the candidate that he or she has the appropriate, specific relevant skills pursuant to WAC 181-78A-270.

(C) An approved preparation program for superintendents shall require an internship of at least three hundred sixty hours.

(D) An approved preparation program for principals shall require for those persons beginning their internship August 1, 2009, and after, an internship which requires practice as an intern ((~~during the~~)) for five hundred forty hours of which at least one-half shall be during school hours, when students and/or staff are present, and for the duration of a full school year. A "full school year" shall mean ((~~five hundred forty hours of which at least one-half shall be during school hours, when students and/or staff are present~~)) at least the academic year: Provided further, That an approved preparation program for principals shall require an internship that shall include demonstration by the candidate that she or he has the appropriate, specific skills pursuant to the standards identified in WAC 181-78A-270(2) and meets, at minimum, the standards-based benchmarks approved and published by the professional educator standards board. The benchmarks may not be changed without prior professional educator standards board approval.

(4) Collaboration.

(a) Faculty within the program and unit collaborate for continuous program improvement.

(b) Faculty collaborate with content area specialists.

(c) Programs collaborate with P-12 schools to assess and respond to work force, student learning, and professional development needs.

(d) Faculty collaborate with members of the broader professional community.

(e) Faculty collaborate with members of under-represented populations for program improvement.

(5) Diversity in learning experiences.

(a) Candidates have significant interaction with diverse populations including colleagues, faculty, P-12 practitioners, and P-12 students and families.

(i) Candidates reflect on interactions with diverse populations in order to integrate professional growth in cultural competency as a habit of practice.

(ii) Candidates integrate their cultural and linguistic backgrounds into classroom activities in order to build the multicultural capacity of the preparation program cohort.

(b) Faculty model equity pedagogy through:

(i) Interaction 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 15-22-013
PROPOSED RULES
DEPARTMENT OF AGRICULTURE
[Filed October 23, 2015, 1:32 p.m.]

Continuance of WSR 15-18-071.

Preproposal statement of inquiry was filed as WSR 15-06-051.

Title of Rule and Other Identifying Information: Chapter 16-470 WAC, Quarantine—Agricultural pests.

The agency continues to consider amending the apple maggot quarantine as stated in the CR-102 filed August 28, 2015. However the agency is revising the proposed "Date of intended adoption" for the reasons stated below.

Date of Intended Adoption: March 11, 2016.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is continuing the proposed date of intended adoption to address issues raised by its consultants and by persons from the apple industry and the composting industry during the public comment period and the hearings on October 8 and 9, 2015. The agency has retained the service of consultants to conduct a pest risk analysis of risks associated with composting operations in the pest-free area. Preliminary consultant reports suggest that there are additional potential risks that require further review and analysis. The agency has determined that this information will be necessary to consider for purposes of amending the apple maggot quarantine rules to add a new section allowing for the issuing of special permits for composting municipal green waste in the pest-free area. The pest risk analysis is expected to provide more definitive guidance on risk and mitigation conditions, which will assist the agency in identifying conditions in the proposed special permit rule and potentially preparing an amended small business economic impact statement if such conditions are to be identified in the amended special permit rule section. The agency may propose an additional hearing and comment period depending on the decisions it makes about the special permit rule section following receipt of the pest risk analysis.

Statutory Authority for Adoption: RCW 14.24.011, 17.24.041, and chapter 34.05 RCW.

Statute Being Implemented: Chapter 17.24 RCW.

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

Name of Proponent: Department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: James Marra, 1111 Washington Street S.E., Olympia, WA 98504-2560, (360) 902-2071.

A small business economic impact statement has been prepared under chapter 19.85 RCW. [See WSR 15-18-071.]

A copy of the statement may be obtained by contacting Teresa Norman, P.O. Box 42560, Olympia, WA 98504-2560, phone (360) 902-2043, fax (360) 902-2092, e-mail wsdarules coments@agr.wa.gov [wsdarulescomments@agr.wa.gov].

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).

October 23, 2015
Brad White
Assistant Director

WSR 15-22-023
PROPOSED RULES
DEPARTMENT OF LICENSING
[Filed October 26, 2015, 3:33 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-08-056.

Title of Rule and Other Identifying Information: Chapter 308-125 WAC.

Hearing Location(s): Department of Licensing, Business and Professions Division, Real Estate Programs, 2000 4th Avenue West, 2nd Floor Conference Room, Olympia, WA 98502, on December 9, 2015, at 10:30 a.m.

Date of Intended Adoption: December 10, 2015.

Submit Written Comments to: Dee A. Sharp, P.O. Box 9021, Olympia, WA 98507-9021, e-mail dsharp@dol.wa.gov, fax (360) 570-4981, by December 8, 2015.

Assistance for Persons with Disabilities: Contact Tambra McCowan by December 8, 2015, TTY (360) 664-8885 or (360) 664-6504.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 308-125-025 Application process to register as a real estate appraiser trainee, housekeeping change to remove [an] effective date [in] subsection (2)(d).

WAC 308-125-030 Examination prerequisite general classification, update education requirements as required by the appraiser qualifications board.

WAC 308-125-040 Examination prerequisite state-certified residential classification, update education requirements as required by the appraiser qualifications board.

WAC 308-125-045 Examination prerequisite state-licensed classification, update education requirements as required by the appraiser qualifications board.

WAC 308-125-070 Experience requirements, implement changes recommended by the real estate appraiser commission.

WAC 308-125-095 Responsibilities of the appraiser supervisor, housekeeping change to remove [an] effective date [in] subsection (1)(c).

All rule changes are approved and recommended to the director by the real estate appraiser commission. These changes will update education requirements for all classification levels; will implement housekeeping changes recommended by the real estate appraiser commission, and update experience requirements to be consistent with statute.

Reasons Supporting Proposal: Amendment to rule is needed to bring agency into compliance with Title XI as amended by the Dodd-Frank Act.

Statutory Authority for Adoption: RCW 18.140.030 (1) and (15).

Rule is necessary because of federal law, Title XI § 1122(b), 12 U.S.C.

Name of Proponent: Department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Dee A. Sharp, Olympia, (360) 664-6504.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This proposed rule amendment effects [affects] individual licensees and have [has] no impact on small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The department of licensing is not one of the named agencies under RCW 34.05.328 (5)(a)(i).

October 26, 2015
Damon Monroe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-025 Application process to register as a real estate appraiser trainee. (1) Anyone who is not a licensed or certified appraiser or a registered appraiser trainee cannot provide assistance that includes analytical work and exercising discernment or discretion that leads to an appraisal conclusion.

(2) As a prerequisite to registration as a registered appraiser trainee, the applicant shall present evidence satisfactory to the director of successful completion within five years of the date of application of the following appraiser qualifications board modules of qualifying core curriculum of approved qualifying education:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent fifteen hours.

(d) ((~~Effective January 1, 2015,~~)) A course that, at a minimum, complies with the specifications for course content established by the appraiser qualifications board that is oriented toward the expectations for the applicant.

(3) Application for registration as a trainee from persons who have had either a real estate license or real estate appraiser license suspended or revoked shall not be accepted by the department until after the time period of the suspension or revocation has expired.

(4) An applicant for registration as a trainee shall present a completed registration form together with the appropriate fee and copies of core curriculum course completion certificates to the director prior to issuance of the approved trainee registration certificate.

(5) Registration as a trainee may be denied for unprofessional conduct as provided in RCW 18.235.130.

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-030 Examination prerequisite general classification. The general real estate appraiser classification applies to the appraisal of all types of real property.

(1) As a prerequisite to taking the examination for certification as a state-certified general real estate appraiser, an applicant shall present evidence satisfactory to the director that he/she has successfully completed not less than three hundred hours in the following core modules:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent, fifteen hours.

(d) General appraiser market analysis and highest and best use, thirty hours.

(e) Statistics, modeling and finance, fifteen hours.

(f) General appraiser sales comparison approach, thirty hours.

(g) General appraiser site valuation and cost approach, thirty hours.

(h) General appraiser income approach, sixty hours.

(i) General appraiser report writing and case studies, thirty hours.

(j) Appraisal subject matter electives, thirty hours.

(2) Credit towards qualifying education requirements may be obtained via the completion of a degree program in real estate from an accredited degree-granting college or university provided the college or university has had its curriculum reviewed and approved by the appraiser qualifications board.

(3) An original certification as a state-certified general real estate appraiser shall not be issued to any person who does not possess three thousand hours of appraisal experience obtained continuously over a period of not less than thirty months in Washington or in another state having comparable certification requirements.

(4) To fulfill the experience requirement, an applicant must have at least one thousand five hundred hours of nonresidential appraisal experience.

(5) ((~~Effective January 1, 2015,~~)) Applicants for the certified general license must possess a bachelor's degree or higher in any field of study. ((~~Through December 31, 2014, applicants for the certified general license must possess a bachelor's degree or higher in any field of study or, in lieu of the required degree, thirty semester credit hours covering the following subject matter courses:~~

~~(a) English composition;~~

~~(b) Principles of economics (micro and macro);~~

~~(c) Finance;~~

~~(d) Algebra, geometry or, higher mathematics;~~

~~(e) Statistics;~~

~~(f) Introduction to computers: Word processing/spreadsheets;~~

~~(g) Business or real estate law; and~~

~~(h) Two elective courses in accounting, geography, agricultural economics, business management, or real estate;~~

~~as approved by the appraiser qualifications board and the director, in addition to the required qualifying core curriculum requirements.~~))

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-040 Examination prerequisite state-certified residential classification. The state-certified residential real estate appraiser classification applies to appraisals of all types of residential property of one to four units without regard to transaction value or complexity and nonresidential property having a transaction value less than two hundred fifty thousand dollars.

(1) As a prerequisite to taking the examination for certification as a state-certified residential real estate appraiser, an applicant shall present evidence satisfactory to the director that he/she has successfully completed not less than two hundred hours in the following core modules:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent, fifteen hours.

(d) Residential market analysis and highest and best use, fifteen hours.

(e) Residential appraiser site valuation and cost approach, fifteen hours.

(f) Residential sales comparison and income approaches, thirty hours.

(g) Residential appraiser report writing and case studies, fifteen hours.

(h) Statistics, modeling and finance, fifteen hours.

(i) Advanced residential applications and case studies, fifteen hours.

(j) Appraisal subject matter electives, twenty hours.

(2) Credit towards qualifying education requirements may be obtained via the completion of a degree program in real estate from an accredited degree-granting college or university provided the college or university has had its curriculum reviewed and approved by the appraiser qualifications board.

(3) An original certification as a state-certified residential real estate appraiser shall not be issued to any person who does not possess two thousand five hundred hours of appraisal experience obtained continuously over a period of not less than twenty-four months in Washington or in another state having comparable certification requirements.

(4) ((~~Effective January 1, 2015,~~)) Applicants for the certified residential appraiser license must possess a bachelor's degree or higher in any field of study. ((~~Through December 31, 2014, certified residential real estate appraiser applicants must possess an associate degree or higher in any field of study or, in lieu of the required degree, twenty-one semester credit hours covering the following subject matter courses:~~

~~(a) English composition;~~

~~(b) Principles of economics (micro or macro);~~

~~(c) Finance;~~

~~(d) Algebra, geometry or, higher mathematics;~~

~~(e) Statistics;~~

~~(f) Introduction to computers: Word processing/spreadsheets; and~~

~~(g) Business or real estate law;~~

~~as approved by the appraiser qualifications board and the director, in addition to the required core curriculum.~~))

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-045 Examination prerequisite state-licensed classification. The state-licensed real estate appraiser classification applies to appraisal of noncomplex one to four residential units having a transaction value less than one million dollars and complex one to four residential units having a transaction value less than two hundred fifty thousand dollars and nonresidential property having a transaction value less than two hundred fifty thousand dollars.

(1) As a prerequisite to taking the examination for certification as a state-licensed real estate appraiser, an applicant shall present evidence satisfactory to the director that he/she has successfully completed not less than one hundred fifty hours in the following core modules:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent, fifteen hours.

(d) Residential market analysis and highest and best use, fifteen hours.

(e) Residential appraiser site valuation and cost approach, fifteen hours.

(f) Residential sales comparison and income approaches, thirty hours.

(g) Residential appraiser report writing and case studies, fifteen hours.

(2) Credit toward qualifying education requirements may be obtained via the completion of a degree program in real estate from an accredited degree-granting college or university provided the college or university has had its curriculum reviewed and approved by the appraiser qualifications board.

(3) An original certification as a state-licensed real estate appraiser shall not be issued to any person who does not possess two thousand hours of appraisal experience obtained continuously over a period of not less than twenty-four months in Washington or in another state having comparable certification requirements.

(4) ((~~Effective January 1, 2015,~~)) Applicants for the state-licensed real estate appraiser license must possess an ((~~associate~~)) associate's degree or higher in any field of study, or in lieu of the required degree, thirty semester credit hours of college-level education from an accredited college, junior college, community college, or university.

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-070 Experience requirements. (1) A minimum of two years (twenty-four months) full-time experience within five years of application is required for the state licensed and certified residential appraiser. Certified general applicants must accumulate three thousand hours within a minimum of thirty months and a maximum of seven years. However, no more than one thousand five hundred hours may be credited in any consecutive twelve months for any of the licensing categories.

(2) Any work product claimed for experience credit dated January 1, 1990, and later shall conform to the Uniform Standards of Professional Appraisal Practice in effect at the time the appraisal is completed.

(a) Reports shall be in writing.

(b) An appraisal work file must be available to the director to substantiate work performed.

(c) Appraisal experience must have been performed as a licensed or certified appraiser or a registered trainee to qualify.

(3) A registered trainee may gain experience under the supervision of no more than six supervisory appraisers during his/her trainee period.

(4) The department may request appraiser work files to verify, confirm, or compare entries made on the experience log. Failure to provide work files to the department upon its request may disqualify the reports as qualifying experience.

(5) An applicant for certification or license shall certify, under penalty of perjury, the completion of the required experience.

(6) Appraisal work qualifying for appraisal experience includes, but is not limited to, the following: Fee and staff appraisal, ad valorem tax appraisal, appraisal review, appraisal analysis, appraisal consulting, highest and best use analysis, feasibility analysis/study.

(7) The department may require a supervisory appraiser to certify, under penalty of perjury, the applicant's work experience.

(8) The department may request written reports or work files to verify an applicant's experience.

AMENDATORY SECTION (Amending WSR 13-17-002, filed 8/7/13, effective 9/7/13)

WAC 308-125-095 Responsibilities of the appraiser supervisor. (1) A certified real estate appraiser licensed by the state of Washington may supervise trainees in accordance with the following provisions:

(a) The certified real estate appraiser is in good standing and not subject to any disciplinary action which affects their legal eligibility to engage in appraisal practice within the three years preceding registration to become a supervisory appraiser.

(b) ((~~Effective January 1, 2015,~~)) The certified real estate appraiser shall have been certified for a minimum of three years prior to becoming a supervisory appraiser.

(c) ((~~Effective January 1, 2015,~~)) The certified real estate appraiser shall have completed a course that, at a minimum, complies with the specification for course content established by the appraiser qualifications board. This course must be completed prior to supervising a registered appraiser trainee.

(d) Not more than three real estate appraiser trainees may be supervised in accordance with the appraiser qualifications board standards unless written authorization by the department is granted to exceed that number of trainees at any one time.

(e) Supervision of trainees in the process of appraising real property shall occur within the boundaries of the state of Washington and comply with jurisdictional and established agreements with other states. If a trainee is supervised by a certified appraiser who is licensed in both the state of Washington and with another state or has a temporary license in another state; and the trainee is registered as a trainee in that other state by either temporary permit, license, or registration, then the appraisal assignments shall qualify as work experience on the experience log.

(f) Authorization to exceed supervision of three trainees may be granted by the director upon approval of a written request and under the provisions of subsection (2) of this section.

(g) A registered real estate appraiser trainee may assist in the completion of an appraisal report, including determination of an opinion of value and may sign the appraisal report, provided that he/she is actively and personally supervised by a state-certified real estate appraiser, and provided that the appraisal report is reviewed and signed by the state-certified real estate appraiser; and provided the state-certified appraiser accepts total responsibility for the appraisal report.

(h) The certified appraiser shall:

(i) Personally inspect with the trainee, at a minimum, the interior of twenty-five subject properties, or until the supervisory appraiser considers the trainee competent.

(ii) Personally review and verify each appraisal report prepared by the trainee as entered on the trainee experience log as qualifying work experience prior to the log being submitted to the department by the supervised trainee. The trainee shall be entitled to obtain copies of the appraisal reports in which the trainee provided appraisal assistance.

(iii) Personally review and verify each appraisal report prepared by a state licensed or certified residential appraiser as entered on the qualifying work experience log prior to the log being submitted to the department by the licensee. The state licensed or certified residential appraiser shall be entitled to obtain copies of the appraisal reports in which the state licensed and certified residential appraiser provided appraisal assistance.

(iv) Comply with all USPAP requirements.

(v) Maintain a separate "properties inspected with trainee" log for each supervised trainee. This log must be made available to the department upon request and is to be submitted with trainee's application for license or certification.

(vi) Register with the department as a supervisory appraiser and include the names of the registered real estate appraiser trainees being supervised. Registration must be five business days prior to the start of supervision. The supervisory appraiser shall notify the department when they are no longer a supervisory appraiser of a trainee, with such notice including the name, address, and registration number of the registered trainee.

(2) Authorization may be granted by the director to a certified appraiser to exceed the number of trainees allowed to be supervised providing:

(a) The certified appraiser has more than five years certified experience.

(b) The certified appraiser shall make a written application to the department requesting to supervise not more than three trainees with less than one year experience; and three trainees with more than one year experience; and five trainees with greater than two years experience. The total number of supervised trainees shall not exceed eight for all experience levels at any one time.

(c) The certified appraiser shall prepare and maintain trainee progress reports and make them available to the department until such time as the trainee becomes certified or licensed or after two years has lapsed since supervising the trainee.

(d) The certified appraiser shall provide to the department a mentoring plan for consideration prior to the department authorizing supervision of more than three trainees.

WSR 15-22-045
PROPOSED RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed October 29, 2015, 9:08 a.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: The following sections within chapter 182-530 WAC, Prescription drugs (outpatient), WAC 182-530-1075, 182-530-3000, 182-530-3100, 182-530-4000, 182-530-4050, 182-530-4150, 182-530-5000, 182-530-5050, 182-530-5100, 182-530-6000, 182-530-7050, 182-530-7100, 182-530-7150, 182-530-7200, 182-530-7250, 182-530-7300, 182-530-7350, 182-530-7400, 182-530-7500, 182-530-7600, 182-530-7800, 182-530-7900, 182-530-8000, 182-530-8050, 182-530-8100, and 182-530-8150.

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 December 8, 2015, at 10:00 a.m.

Date of Intended Adoption: Not sooner than December 9, 2015.

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 December 8, 2015.

Assistance for Persons with Disabilities: Contact Amber Lougheed, TTY (800) 848-5429 or (360) 725-1349 or e-mail amber.lougheed@hca.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is making housekeeping changes to update agency names and rule citations.

Reasons Supporting Proposal: The proposed rules improve clarity for the reader without changing the effect of the rules.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, (360) 725-1408; Implementation and Enforcement: Charles Agte, P.O. Box 45506, (360) 725-1301.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed filing does not create a disproportionate 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.

October 29, 2015
Wendy Barcus
Rules Coordinator

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

WAC 182-530-1075 Requirements—Use of tamper-resistant prescription pads. (1) The ((department)) medicaid agency requires providers to use tamper-resistant prescription pads or paper for written outpatient prescriptions, including over-the-counter drugs, for ((medical assistance)) Washington apple health clients.

(2) This requirement applies to all outpatient prescription drugs, including:

(a) Prescriptions when medicaid is primary or secondary payer (including medicare Part D prescriptions).

(b) Signed hardcopy prescriptions given to a client, whether handwritten or computer-generated.

(3) This requirement does not apply to:

(a) Prescriptions paid for by Washington's healthy options (HO) program or other ((department)) agency-contracted managed care organizations.

(b) Prescription drugs that are part of the per diem or bundled rate and not reimbursed separately in designated institutional or clinical settings, such as a nursing facility, ICF/MR, dental office, hospice, or radiology. For example, a morphine prescription used to control a hospice client's cancer pain is covered under the hospice per diem rate and therefore the tamper-resistant prescription requirement is not required.

(c) Telephone, fax, or electronic prescriptions.

(d) Refill prescriptions, if the original written prescriptions were presented at a pharmacy before April 1, 2008.

(e) Prescriber or clinic drug samples given directly to the client.

(f) An institutional setting, as defined in WAC ((388-500-0005)) 182-500-0050, where the prescriber writes the order into the medical records and the orders go directly to the pharmacy.

(4) Effective April 1, 2008, the tamper-resistant prescription pads and paper must meet at least one of the following industry recognized characteristics:

(a) One or more features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One or more features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or

(c) One or more features designed to prevent the use of counterfeit prescription forms.

(5) Effective October 1, 2008, the tamper-resistant prescription pads and paper must contain all of the three characteristics in subsection (4) of this section.

(6) If the written prescription is not on tamper-resistant paper, the pharmacy may provide the prescription on an emergency basis. The pharmacy must verify the prescription with the prescriber by telephone, fax, or electronic communication, or by physical receipt of a tamper-resistant written prescription within seventy-two hours of filling the prescription.

(7) Federal controlled substance laws on controlled substances apply when prescribing or dispensing schedule II drugs.

(8) Record retention requirements (((WAC 388-502-0020))) under WAC 182-502-0020 remain in effect. Additional documentation is required as follows:

(a) Documentation by the pharmacy of verbal confirmation of a noncompliant written prescription.

(b) Documentation by the pharmacy of verbal confirmation about the authenticity of the tamper-resistant prescription.

(9) To submit a claim for a medicaid client retroactively certified for medicaid, the following applies:

(a) The prescription must meet the tamper-resistant compliance requirement.

(b) Refills that occur after the date on which the client is determined to be eligible require a new, tamper-resistant prescription in compliance with this WAC.

(c) If the original order is not compliant with subsection (4) of this section, the pharmacy must obtain a verbal, faxed, or email confirmation of the prescription from the prescriber.

(d) The pharmacy must reimburse the client ((in accordance with WAC 388-502-0160)) under WAC 182-502-0160.

(10) The pharmacy accepting a prescription transfer from another pharmacy must confirm the authenticity of the prescription by telephone or facsimile from the transferring pharmacy.

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

WAC 182-530-3000 When the ((department)) medicaid agency requires authorization. Pharmacies must obtain authorization for covered drugs, devices, or drug-related supplies in order to receive reimbursement as described in this section.

(1) The ((department's)) medicaid agency's pharmacists and medical consultants:

(a) Have determined that authorization for the drug, device, or drug-related supply is required, as described in WAC ((388-530-3100)) 182-530-3100; or

(b) Have not yet reviewed the manufacturer's dossier of drug information submitted in the Academy of Managed Care Pharmacy (AMCP) format.

(2) The drug, device, or drug-related supply is in the therapeutic drug class on the Washington preferred drug list and the product is one of the following:

(a) Nonpreferred as described in WAC ((388-530-4100)) 182-530-4100; and

(i) The prescriber is a nonendorsing practitioner; or

(ii) The drug is designated as exempt from the therapeutic interchange program per WAC ((388-530-4100(6) or 388-530-4150 (2)(c))) 182-530-4100(6) or 182-530-4150 (2)(a);

(b) Preferred for a special population or specific indication and has been prescribed by a nonendorsing practitioner under conditions for which the drug, device, or drug-related supply is not preferred; or

(c) Determined to require authorization for safety.

(3) For the purpose of promoting safety, efficacy, and effectiveness of drug therapy, the ((~~department~~)) agency identifies clients or groups of clients who would benefit from further clinical review.

(4) The ((~~department~~)) agency designates the prescriber(s) as requiring authorization because the prescriber(s) is under ((~~department~~)) agency review or is sanctioned for substandard quality of care.

(5) Utilization data indicate there are health and safety concerns or the potential for misuse and abuse. Examples of utilization concerns include:

(a) Multiple prescriptions filled of the same drug in the same calendar month;

(b) Prescriptions filled earlier than necessary for optimal therapeutic response;

(c) Therapeutic duplication;

(d) Therapeutic contraindication;

(e) Excessive dosing, excessive duration of therapy, or subtherapeutic dosing as determined by FDA labeling or the compendia of drug information; and

(f) Number of prescriptions filled per month in total or by therapeutic drug class.

(6) The pharmacy requests reimbursement in excess of the maximum allowable cost and the drug has been prescribed with instructions to dispense as written.

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

WAC 182-530-3100 How the ((~~department~~)) medicaid agency determines when a drug requires authorization. (1) The ((~~department's~~)) medicaid agency's pharmacists and medical consultants evaluate new covered drugs, new covered indications, or new dosages approved by the Food and Drug Administration (FDA) to determine the drug authorization requirement.

(a) The clinical team uses a drug evaluation matrix to evaluate and score the benefit/risk assessment and cost comparisons of drugs to similar existing drugs based on quality evidence contained in compendia of drug information and peer-reviewed medical literature.

(b) In performing this evaluation the clinical team may consult with other ((~~department~~)) agency clinical staff, financial experts, and program managers. The ((~~department~~)) agency may also consult with an evidence-based practice center, the drug use review (DUR) board, and((~~/or~~)) medical experts in this evaluation.

(c) Information reviewed in the drug evaluation matrix includes, but is not limited to, the following:

(i) The drug, device, or drug-related supply's benefit/risk ratio;

(ii) Potential for clinical misuse;

(iii) Potential for client misuse/abuse;

(iv) Narrow therapeutic indication;

(v) Safety concerns;

(vi) Availability of less costly therapeutic alternatives; and

(vii) Product cost and outcome data demonstrating the drug, device, or drug-related supply's cost effectiveness.

(d) Based on the clinical team's evaluation and the drug evaluation matrix score, the ((~~department~~)) agency may determine that the drug, device, or drug-related supply:

(i) Requires authorization;

(ii) Requires authorization to exceed ((~~department~~)) agency-established limitations; or

(iii) Does not require authorization.

(2) Drugs in therapeutic classes on the Washington preferred drug list are not subject to determination of authorization requirements through the drug evaluation matrix. Authorization requirements are determined by their preferred status according to WAC ((~~388-530-4100~~)) 182-530-4100.

(3) The ((~~department~~)) agency periodically reviews existing drugs, devices, or drug-related supplies and reassigns authorization requirements as necessary according to the same provisions as outlined above for new drugs, devices, or pharmaceutical supplies.

(4) For any drug, device, or drug-related supply with limitations or requiring authorization, the ((~~department~~)) agency may elect to apply automated authorization criteria according to WAC ((~~388-530-3200~~)) 182-530-3200.

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

WAC 182-530-4000 Drug use review (DUR) board. In accordance with 42 C.F.R. 456.716, the ((~~department~~)) medicaid agency establishes a drug use review (DUR) board.

(1) The DUR board:

(a) Includes health professionals who are actively practicing and licensed in the state of Washington and who have recognized knowledge and expertise in one or more of the following:

(i) The clinically appropriate prescribing of outpatient drugs;

(ii) The clinically appropriate dispensing and monitoring of outpatient drugs;

(iii) Drug use review, evaluation, and intervention; and

(iv) Medical quality assurance.

(b) Is made up of at least one-third but not more than fifty-one percent physicians, and at least one-third pharmacists.

(2) The ((~~department~~)) agency may appoint members of the pharmacy and therapeutics committee established by the ((~~health care authority (HCA)~~)) agency under chapter 182-50 WAC or other qualified individuals to serve as members of the DUR board.

(3) The DUR board meets periodically to:

(a) Advise the ((~~department~~)) agency on drug use review activities;

(b) Review provider and patient profiles;

(c) Review scientific literature to establish evidence-based guidelines for the appropriate use of drugs, including the appropriate indications and dosing;

(d) Recommend adoption of standards and treatment guidelines for drug therapy;

(e) Recommend interventions targeted toward correcting drug therapy problems; and

(f) Produce an annual report.

(4) The ((~~department~~)) agency has the authority to accept or reject the recommendations of the DUR board in accordance with 42 C.F.R. 456.716(c).

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

WAC 182-530-4050 Drug use and claims review. (1) The ((~~department's~~)) agency's drug use review (DUR) consists of:

(a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:

(i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition((~~(s)~~)) or conditions which may relate to drug utilization;

(ii) Screen for potential drug therapy problems; and

(iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations.

(b) A retrospective drug use review (Retro-DUR), in which the ((~~department~~)) agency provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

(2) The ((~~department~~)) agency reviews a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, the ((~~department~~)) agency may implement corrective action that includes, but is not limited to:

(a) Educating the provider regarding the problem practice((~~(s)~~)) or practices;

(b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;

(c) Recouping the payment for the drug((~~(s); and/~~)) or drugs; or

(d) Terminating the provider's core provider agreement (CPA).

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

WAC 182-530-4150 Therapeutic interchange program (TIP). This section contains the ((~~department's~~)) medicaid agency's rules for the endorsing practitioner therapeutic interchange program (TIP). TIP is established under RCW 69.41.190 and 70.14.050. The statutes require state-operated prescription drug programs to allow physicians and other prescribers to endorse a Washington preferred drug list (PDL) and, in most cases, requires pharmacists to automatically substitute a preferred, equivalent drug from the list.

(1) The therapeutic interchange program (TIP) applies only to drugs:

(a) Within therapeutic classes on the Washington PDL;

(b) Studied by the evidence-based practice center((~~(s)~~)) or centers;

(c) Reviewed by the pharmacy and therapeutics (P&T) committee; and

(d) Prescribed by an endorsing practitioner.

(2) TIP does not apply:

(a) When the P&T committee determines that TIP does not apply to the therapeutic class on the PDL; or

(b) To a drug prescribed by a nonendorsing practitioner.

(3) A practitioner who wishes to become an endorsing practitioner must specifically enroll with the health care authority (HCA) as an endorsing practitioner under the provisions of chapter 182-50 WAC and RCW 69.41.190(2).

(4) When an endorsing practitioner writes a prescription for a client for a nonpreferred drug, or for a preferred drug for a special population or indication other than the client's population or indication, and indicates that substitution is permitted, the pharmacist must:

(a) Dispense a preferred drug in that therapeutic class in place of the nonpreferred drug; and

(b) Notify the endorsing practitioner of the specific drug and dose dispensed.

(5) With the exception of subsection (7) and (10) of this section, when an endorsing practitioner determines that a nonpreferred drug is medically necessary, all of the following apply:

(a) The practitioner must indicate that the prescription is to be dispensed as written (DAW);

(b) The pharmacist dispenses the nonpreferred drug as prescribed; and

(c) The ((~~department~~)) agency does not require prior authorization to dispense the nonpreferred drug in place of a preferred drug except when the drug requires authorization for safety.

(6) In the event the following therapeutic drug classes are on the Washington PDL, pharmacists will not substitute a preferred drug for a nonpreferred drug in these therapeutic drug classes when the endorsing practitioner prescribes a refill (including the renewal of a previous prescription or adjustments in dosage):

(a) Antipsychotic;

(b) Antidepressant;

(c) Antiepileptic;

(d) Chemotherapy;

(e) Antiretroviral;

(f) Immunosuppressive; or

(g) Immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks.

(7) The ((~~department~~)) agency may impose nonendorsing status on an endorsing practitioner only under the following circumstances:

(a) The ((~~department~~)) agency runs three quarterly reports demonstrating that, within any therapeutic class of drugs on the Washington PDL, the endorsing practitioner's frequency of prescribing DAW varies from the prescribing patterns of the endorsing practitioner's ((~~department~~)) agency-designated peer grouping with a ninety-five percent confidence interval; and

(b) The medical director has:

(i) Delivered by mail to the endorsing practitioner the quarterly reports described in ((~~subsection (7)~~)) (a) of this ((~~section~~)) subsection, which demonstrate the endorsing practitioner's variance in prescribing patterns; and

(ii) Provided the endorsing practitioner an opportunity to explain the variation in prescribing patterns as medically necessary as defined under WAC ((~~388-500-0005~~)) 182-500-0070; or

(iii) Provided the endorsing practitioner two calendar quarters to change ((~~his or her~~)) their prescribing patterns to align with those of the ((~~department~~)) agency-designated peer groupings.

(8) While the endorsing practitioner is engaged in the activities described in subsection (7)(b)(ii) or (((~~(7)(b)~~)) (iii) of this section, ((~~his or her~~)) their endorsing practitioner status is maintained.

(9) The nonendorsing status restrictions imposed under this section will remain in effect until the quarterly reports demonstrate that the endorsing practitioner's prescribing patterns no longer vary in comparison to ((~~his or her department~~)) the endorsing practitioner's agency-designated peer-grouping over a period of four calendar quarters, with a ninety-five percent confidence interval.

(10) Except as otherwise provided in subsection (11) of this section, for a client's first course of treatment within a therapeutic class of drugs, the endorsing practitioner's option to write DAW does not apply when:

(a) There is a less expensive, equally effective therapeutic alternative generic product available to treat the condition; and

(b) The drug use review (DUR) board established under WAC ((~~388-530-4000~~)) 182-530-4000 has reviewed the drug class and recommended to the ((~~department~~)) agency that the drug class is appropriate to require generic drugs as a client's first course of treatment.

(11) In accordance with WAC ((~~388-530-4125(3) and WAC 388-501-0165, the department~~)) 182-530-4125(3) and 182-501-0165, the agency will request and review the endorsing practitioner's medical justification for preferred and nonpreferred brand name drugs and nonpreferred generic drugs for the client's first course of treatment.

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

WAC 182-530-5000 Billing requirements—Pharmacy claim payment. (1) When billing the ((~~department~~)) medicaid agency for pharmacy services, providers must:

(a) Use the appropriate ((~~department~~)) agency claim form or electronic billing specifications;

(b) Include the actual eleven-digit national drug code (NDC) number of the product dispensed from a rebate eligible manufacturer;

(c) Bill the ((~~department~~)) agency using metric decimal quantities which is the National Council for Prescription Drug Programs (NCPDP) billing unit standard;

(d) Meet the general provider documentation and record retention requirements in WAC ((~~388-502-0020~~)) 182-502-0020; and

(e) Maintain proof of delivery receipts.

(i) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery including signature, client's name and a detailed description of the item((~~(s)~~)) or items delivered.

(ii) When a provider mails an item to the client, the provider must be able to furnish proof of delivery including a mail log.

(iii) When a provider uses a delivery((~~/~~)) or shipping service to deliver items, the provider must be able to furnish proof of delivery and it must:

(A) Include the delivery service tracking slip with the client's name or a reference to the client's package((~~(s)~~)) or packages; the delivery service package identification number; and the delivery address.

(B) Include the supplier's shipping invoice, with the client's name; the shipping service package identification number; and a detailed description((~~(s)~~)).

(iv) Make proof of delivery receipts available to the ((~~department,~~)) agency upon request.

(2) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code((~~(s)~~)) or codes in the appropriate data field on the drug claim.

(3) Pharmacy services for clients on restriction under WAC ((~~388-501-0135~~)) 182-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

(a) Emergency;

(b) Family planning services; or

(c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

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

WAC 182-530-5050 Billing requirements—Point-of-sale (POS) system/prospective drug use review (Pro-DUR). (1) Pharmacy claims for drugs and other products listed in the ((~~department's~~)) medicaid agency's drug file and billed to the ((~~department~~)) agency by national drug code (NDC) are adjudicated by the ((~~department's~~)) agency's point-of-sale (POS) system. Claims must be submitted for payment using the billing unit standard identified in WAC ((~~388-530-5000~~)) 182-530-5000.

(2) All pharmacy drug claims processed through the POS system undergo a system-facilitated prospective drug use review (Pro-DUR) screening as a complement to the Pro-DUR screening required of pharmacists.

(3) If the POS system identifies a potential drug therapy problem during Pro-DUR screening, a message will alert the pharmacy provider indicating the type of potential problem. The alerts regarding possible drug therapy problems include, but are not limited to:

(a) Therapeutic duplication;

(b) Duration of therapy exceeds the recommended maximum period;

(c) Drug-to-drug interaction;

(d) Drug disease precaution;

(e) High dose;

(f) Ingredient duplication;

(g) Drug-to-client age conflict;

(h) Drug-to-client gender conflict; or

(i) Refill too soon.

(4) The ((~~department~~)) agency provides pharmacy providers with a list of codes from which to choose in overriding POS system alert messages. These codes come from the National Council for Prescription Drug Programs (NCPDP).

(5) The dispensing pharmacist evaluates the potential drug therapy conflict and enters applicable NCPDP codes representing their professional interaction.

(a) If the resolution to the conflict satisfies ((~~department~~)) agency requirements, the claim will be processed accordingly.

(b) If the resolution to the conflict does not satisfy ((~~department~~)) agency requirements, the ((~~department~~)) agency requires prior authorization. This includes all claims for which an alert message is triggered in the POS system and an NCPDP override code is not appropriate.

(6) The ((~~department~~)) agency requires providers to retain documentation of the justification for the use of payment system override codes as described in subsections (4) and (5) of this section. The ((~~department~~)) agency requires the documentation be retained for the same period as that described in WAC ((~~388-502-0020~~)) 182-502-0020.

(7) POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

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

WAC 182-530-5100 Billing requirements—Unit dose. (1) To be eligible for a unit dose dispensing fee from the ((~~department~~)) medicaid agency, a pharmacy must:

(a) Notify the ((~~department~~)) agency in writing of its intent to provide unit dose service;

(b) Identify the nursing ((~~facility(ies)~~)) facility or facilities to be served;

(c) Indicate the approximate date unit dose service to the ((~~facility(ies)~~)) facility or facilities will commence; and

(d) Follow ((~~department~~)) agency requirements for unit dose payment.

(2) Under a unit dose delivery system, a pharmacy must bill only for the number of drug units actually used by the ((~~medical assistance~~)) client in the nursing facility, except as provided in subsections (3), (4), and (5) of this section. It is the unit dose pharmacy provider's responsibility to coordinate with nursing facilities to ensure that the unused drugs the pharmacy dispensed to clients are returned to the pharmacy for credit.

(3) The pharmacy must submit an adjustment form or claims reversal of the charge to the ((~~department~~)) agency for the cost of all unused drugs returned to the pharmacy from the nursing facility on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (5) of this section. Such adjustment must conform to the nursing facility's monthly log as described in subsection (7) of this section.

(4) The ((~~department~~)) agency pays a unit dose provider a dispensing fee when a provider-packaged unit dose prescription is returned, in its entirety, to the pharmacy. A dispensing fee is not paid if the returned prescription is for a drug with a manufacturer-designated unit dose national drug code (NDC). In addition to the dispensing fee paid under this subsection, the provider may bill the ((~~department~~)) agency one unit of the tablet or capsule but must credit the ((~~department~~)) agency for the remainder of the ingredient costs for the returned prescription.

(5) Unit dose providers do not have to credit the ((~~department~~)) agency for federally designated schedule two drugs which are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

(6) Pharmacies must not charge clients or the ((~~department~~)) agency a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's drug delivery system; or

(b) For the nursing facility's convenience.

(7) The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility served((~~;~~)) including, but not limited to, the following information:

(a) Facility name and address;

(b) Client's name and patient identification code (PIC);

(c) Drug name/strength;

(d) National drug code (NDC);

(e) Quantity and date dispensed;

(f) Quantity and date returned;

(g) Value of returned drugs or amount credited;

(h) Explanation for no credit given or nonreusable returns; and

(i) Prescription number.

(8) Upon the ((~~department's~~)) agency's request, the pharmacy must submit copies of the logs referred to in subsection (7) of this section.

(9) When the pharmacy submits the completed annual prescription volume survey to the ((~~department~~)) agency, it must include an updated list of all nursing facilities currently served under unit dose systems.

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

WAC 182-530-6000 Mail-order services. The ((~~department~~)) medicaid agency provides a contracted mail-order pharmacy service for client use. The mail-order contractor is selected as a result of a competitive procurement process.

(1) The contracted mail-order pharmacy service is available as an option to all ((~~medical assistance~~)) Washington apple health clients, subject to the:

(a) Scope of the client's medical care program;

(b) Availability of services from the contracted mail-order provider; and

(c) Special terms and conditions described in subsection (2) and (3) of this section.

(2) The mail-order prescription service may not dispense medication in a quantity greater than authorized by the prescriber. (See RCW 18.64.360(5), Nonresident pharmacies.)

(3) Prescribed medications may be filled by the mail-order pharmacy service within the following restrictions:

(a) Drugs available from mail-order in no more than a ninety-day supply include:

(i) Preferred drugs (see WAC ((~~388-530-4100~~)) 182-530-4100);

(ii) Generic drugs; and

(iii) Drugs that do not have authorization requirements (see WAC ((~~388-530-3000 through 388-530-3200~~)) 182-530-3000 through 182-530-3200).

(b) Drugs available in no more than a thirty-four-day supply:

(i) Controlled substances (schedules II through V); and

(ii) Drugs having authorization requirements (see WAC ((~~388-530-3000~~)) 182-530-3000).

(c) Other pharmacy restrictions (chapter ((~~388-530 WAC, Pharmacy services~~)) 182-530 WAC Prescription drugs (outpatient)) continue to apply.

(4) The contracted mail-order pharmacy services are reimbursed at levels lower than those established for the regular outpatient pharmacy services.

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

WAC 182-530-7050 Reimbursement—Dispensing fee determination. (1) Subject to the provisions of WAC ((~~388-530-7000~~)) 182-530-7000 and the exceptions permitted in WAC ((~~388-530-2000~~)) 182-530-2000, the ((~~department~~)) medicaid agency pays a dispensing fee for each covered, prescribed drug.

(2) The ((~~department~~)) agency does not pay a dispensing fee for nondrug items, devices, or drug-related supplies.

(3) The ((~~department~~)) agency adjusts the dispensing fee by considering factors including, but not limited to:

(a) Legislative appropriations for vendor rates;

(b) Input from provider and ((~~/or~~)) advocacy groups;

(c) Input from state-employed or contracted actuaries; and

(d) Dispensing fees paid by other third-party payers((~~,~~)) including, but not limited to, health care plans and other states' medicaid agencies.

(4) The ((~~department~~)) agency uses a tiered dispensing fee system which pays higher volume pharmacies at a lower fee and lower volume pharmacies at a higher fee.

(5) The ((~~department~~)) agency uses total annual prescription volume (both medicaid and nonmedicaid) reported to the ((~~department~~)) agency to determine each pharmacy's dispensing fee tier.

(a) A pharmacy which fills more than thirty-five thousand prescriptions annually is a high-volume pharmacy. The ((~~department~~)) agency considers hospital-based pharmacies that serve both inpatient and outpatient clients as high-volume pharmacies.

(b) A pharmacy which fills between fifteen thousand one and thirty-five thousand prescriptions annually is a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually is a low-volume pharmacy.

(6) The ((~~department~~)) agency determines a pharmacy's annual total prescription volume as follows:

(a) The ((~~department~~)) agency sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies return completed prescription volume surveys to the ((~~department~~)) agency each year. Pharmacy providers not responding to the survey by the specified date are assigned to the high volume category;

(c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count;

(d) The ((~~department~~)) agency considers prescriptions dispensed to nursing facility clients as outpatient prescriptions; and

(e) Assignment to a new dispensing fee tier is effective on the first of the month, following the date specified by the ((~~department~~)) agency.

(7) A pharmacy may request a change in dispensing fee tier during the interval between the annual prescription volume surveys. The pharmacy must substantiate such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for the new tier. If the ((~~department~~)) agency receives the documentation by the twentieth of the month, assignment to a new dispensing fee tier is effective on the first of the following month.

(8) The ((~~department~~)) agency grants general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume).

(9) The ((~~department~~)) agency may pay true unit dose pharmacies at a different rate for unit dose dispensing.

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

WAC 182-530-7100 Reimbursement—Pharmaceutical supplies. (1) The ((~~department~~)) medicaid agency reimburses for selected pharmaceutical supplies through the pharmacy point-of-sale (POS) system when it is necessary for client access and safety.

(2) The ((~~department~~)) agency bases reimbursement of pharmaceutical items or supplies that are not payable through the POS on ((~~department~~)) agency-published fee schedules.

(3) The ((~~department~~)) agency uses any or all of the following methodologies to set the maximum allowable reimbursement rate for drugs, devices, and drug-related supplies:

(a) A pharmacy provider's acquisition cost. Upon review of the claim, the ((~~department~~)) agency may require an invoice which must show the name of the item, the manufacturer, the product description, the quantity, and the current cost including any free goods associated with the invoice;

(b) Medicare's reimbursement rate for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

(4) The ((~~department~~)) agency does not pay a dispensing fee for nondrug items, devices, or drug-related supplies. See WAC ((~~388-530-7050~~)) 182-530-7050.

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

WAC 182-530-7150 Reimbursement—Compounded prescriptions. (1) The ((~~department~~)) medicaid agency does not consider reconstitution to be compounding.

(2) The ((~~department~~)) agency covers a drug ingredient used for a compounded prescription only when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services (DHHS).

(3) The ((~~department~~)) agency considers bulk chemical supplies used in compounded prescriptions as nondrug items, which do not require a drug rebate agreement. The ((~~department~~)) agency covers such bulk chemical supplies only as specifically approved by the ((~~department~~)) agency.

(4) The ((~~department~~)) agency reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths ((~~and/~~)) or forms of the medically necessary drug.

(a) The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength ((~~and/~~)) or form is well-documented in the client's file.

(b) The pharmacist must ensure that the ingredients used in a compounded prescription are for an approved use as defined in "medically accepted indication" in WAC ((~~388-530-1050~~)) 182-530-1050.

(5) The ((~~department~~)) agency requires that each drug ingredient used for a compounded prescription be billed to the ((~~department~~)) agency using its eleven-digit national drug code (NDC) number.

(6) Compounded prescriptions are reimbursed as follows:

(a) The ((~~department~~)) agency allows only the lowest cost for each covered ingredient, whether that cost is determined by actual acquisition cost (AAC), estimated acquisition cost (EAC), federal upper limit (FUL), maximum allowable cost (MAC), automated maximum allowable cost (AMAC), or amount billed.

(b) The ((~~department~~)) agency applies current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under ((~~subsection (6)~~)) (c) of this ((~~section~~)) subsection. The ((~~department~~)) agency denies payment for a drug requiring authorization when authorization is not obtained.

(c) The ((~~department~~)) agency may designate selected drugs as not requiring authorization when used for compounded prescriptions. For the list of selected drugs, refer to the ((~~department's~~)) agency's prescription drug program billing instructions.

(d) The ((~~department~~)) agency pays a dispensing fee as described under WAC ((~~388-530-7050~~)) 182-530-7050 for each drug ingredient used in compounding when the conditions of this section are met and each ingredient is billed separately by the eleven-digit NDC.

(e) The ((~~department~~)) agency does not pay a separate fee for compounding time.

(7) The ((~~department~~)) agency requires pharmacists to document the need for each inactive ingredient added to the compounded prescription. The ((~~department~~)) agency limits reimbursement to the inactive ingredients that meet the following criteria. To be reimbursed by the ((~~department~~)) agency, each inactive ingredient must be:

(a) A necessary component of a compounded drug; and

(b) Billed by an eleven-digit national drug code (NDC).

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

WAC 182-530-7200 Reimbursement—Out-of-state prescriptions. (1) The ((~~department~~)) medicaid agency reimburses out-of-state pharmacies for prescription drugs provided to an eligible client within the scope of the client's medical care program if the pharmacy:

(a) Contracts with the ((~~department~~)) agency to be an enrolled provider; and

(b) Meets the same criteria the ((~~department~~)) agency requires for in-state pharmacy providers.

(2) The ((~~department~~)) agency considers pharmacies located in bordering areas listed in WAC ((~~388-501-0175~~)) 182-501-0175 the same as in-state pharmacies.

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

WAC 182-530-7250 Reimbursement—Miscellaneous. The ((~~department~~)) medicaid agency reimburses for covered drugs, devices, and drug-related supplies provided or administered by nonpharmacy providers under specified conditions, as follows:

(1) The ((~~department~~)) agency reimburses for drugs administered or prepared and delivered for individual use by an authorized prescriber during an office visit according to specific program rules found in:

(a) Chapter ((~~388-531~~)) 182-531 WAC((~~,~~)) Physician-related services;

(b) Chapter ((~~388-532~~)) 182-532 WAC((~~,~~)) Reproductive health/family planning only/TAKE CHARGE; and

(c) Chapter ((~~388-540~~)) 182-540 WAC((~~,~~)) Kidney disease program and kidney center services.

(2) Providers who are purchasers of Public Health Services (PHS) discounted drugs must comply with PHS 340b program requirements. (See WAC ((~~388-530-7900~~)) 182-530-7900).

(3) The ((~~department~~)) agency may request providers to submit a current invoice for the actual cost of the drug, device, or drug-related supply billed. If an invoice is requested, the invoice must show the:

(a) Name of the drug, device, or drug-related supply;

(b) Drug or product manufacturer;

(c) NDC of the product((~~(s)~~)) or products;

(d) Drug strength;

(e) Product description;

(f) Quantity; and

(g) Cost, including any free goods associated with the invoice.

(4) The ((~~department~~)) agency does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH). The ((~~department~~)) agency does pay physicians, advanced registered nurse practitioners (ARNP), and pharmacists a fee for administering the vaccine.

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

WAC 182-530-7300 Reimbursement—Requesting a change. Upon request from a pharmacy provider, the ((department)) medicaid agency may reimburse at actual acquisition cost (AAC) for a drug that would otherwise be reimbursed at maximum allowable cost (MAC) when:

(1) The availability of lower cost equivalents in the marketplace is severely curtailed and the price disparity between AAC for the drug and the MAC reimbursement affects clients' access; and

(2) An invoice documenting actual acquisition cost relevant to the date the drug was dispensed is provided to the ((department)) agency.

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

WAC 182-530-7350 Reimbursement—Unit dose drug delivery systems. (1) The ((department)) medicaid agency pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (7) and (8) of this section.

(2) Unit dose delivery systems may be either true or modified unit dose.

(3) The ((department)) agency pays pharmacies that provide unit dose delivery services the ((department's)) agency's highest allowable dispensing fee for each unit dose prescription dispensed to clients in nursing facilities. The ((department)) agency reimburses ingredient costs for drugs under unit dose systems as described in WAC ((388-530-7000)) 182-530-7000.

(4) The ((department)) agency pays a pharmacy that dispenses drugs in bulk containers or multidose forms to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume tier. Drugs the ((department)) agency considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. The ((department)) agency reimburses ingredient costs as described in WAC ((388-530-7000)) 182-530-7000.

(5) The ((department)) agency pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable under WAC ((388-530-7050)) 182-530-7050. The ((department)) agency reimburses ingredient costs for drugs prepackaged by the manufacturer in unit dose form as described in WAC ((388-530-7000)) 182-530-7000.

(6) The ((department)) agency limits its coverage and payment for manufacturer-designated unit dose packaging to the following conditions:

(a) The drug is a single source drug and a multidose package for the drug is not available;

(b) The drug is a multiple source drug but there is no other multidose package available among the drug's generic equivalents; or

(c) The manufacturer-designated unit dose package is the most cost-effective package available or it is the least costly alternative form of the drug.

(7) The ((department)) agency reimburses a pharmacy provider for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise be covered as an outpatient drug. The unit dose dispensing fee does not apply in such cases. The ((department)) agency pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(8) The ((department)) agency may pay for unit dose delivery systems for clients of the ((division of)) developmental disabilities (((DDD))) administration (DDA) residing in approved community living arrangements.

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

WAC 182-530-7400 Reimbursement—Compliance packaging services. (1) The ((department)) medicaid agency reimburses pharmacies for compliance packaging services provided to clients considered at risk for adverse drug therapy outcomes. Clients who are eligible for compliance packaging services must not reside in a nursing home or other inpatient facility, and must meet (a) and either (b) or (c) of this subsection. The client must:

(a) Have one or more of the following representative disease conditions:

(i) Alzheimer's disease;

(ii) Blood clotting disorders;

(iii) Cardiac arrhythmia;

(iv) Congestive heart failure;

(v) Depression;

(vi) Diabetes;

(vii) Epilepsy;

(viii) HIV/AIDS;

(ix) Hypertension;

(x) Schizophrenia; or

(xi) Tuberculosis.

(b) Concurrently consume two or more prescribed medications for chronic medical conditions, that are dosed at three or more intervals per day; or

(c) Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

(2) Compliance packaging services include:

(a) Reusable hard plastic containers of any type (e.g., medisets); and

(b) Nonreusable compliance packaging devices (e.g., blister packs).

(3) The ((department)) agency pays a filling fee and reimburses pharmacies for the compliance packaging device and((/or)) container. The frequency of fills and number of payable compliance packaging devices per client is subject to limits specified by the ((department)) agency. The ((department)) agency does not pay filling or preparation fees for blister packs.

(4) Pharmacies must use the CMS-1500 claim form to bill the ((~~department~~)) agency for compliance packaging services.

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

WAC 182-530-7500 Drug rebate requirement. (1) The ((~~department~~)) medicaid agency reimburses for outpatient prescription drugs only when they are supplied by manufacturers who have a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS), according to 42 U.S.C. 1396r-8. The manufacturer must be listed on the list of participating manufacturers as published by ((~~CMS~~)) the Center for Medicare and Medicaid Services (CMS).

(2) The fill date must be within the manufacturer's beginning and ending eligibility dates to be reimbursed by the ((~~department~~)) agency.

(3) The ((~~department~~)) agency may extend this rebate requirement to any outpatient drug reimbursements as allowed or required by federal law.

(4) The ((~~department~~)) agency may exempt drugs from the rebate requirement, on a case-by-case basis, when:

(a) It determines that the availability of a single source drug or innovator multiple source drug is essential to the health of beneficiaries; and

(b) All other rebate exemption requirements of SSA Sec. 1927 (42 U.S.C. 1396r-8)(3) are also satisfied.

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

WAC 182-530-7600 Reimbursement—Clients enrolled in managed care. Except as specified under the ((~~department's~~)) medicaid agency's managed care contracts, the ((~~department~~)) agency does not reimburse providers for any drugs or pharmaceutical supplies provided to clients who have pharmacy benefits under ((~~department~~)) agency-contracted managed care plans. The managed care plan is responsible for payment.

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

WAC 182-530-7800 Reimbursement—Clients with third-party liability. (1) The ((~~department~~)) medicaid agency requires providers to meet the third-party requirements of WAC ((~~388-501-0200~~)) 182-501-0200.

(2) The following definitions apply to this section:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the ((~~department's~~)) agency's POS system, which requires that coverage be verified by or submitted to the insurer for authorization at the time of service and at the time the prescription is filled.

(3) This subsection applies to clients who have a third-party resource that is a managed care entity other than ((~~a department~~)) an agency-contracted plan, or have other insurance that requires the use of "closed pharmacy networks" or "private point-of-sale authorization system." The ((~~department~~)) agency will not pay pharmacies for prescription drug claims until the pharmacy provider submits an explanation of benefits from the private insurance demonstrating that the pharmacy provider has complied with the terms of the ((~~third-party's~~)) third party's coverage.

(a) If the private insurer pays a fee based on the incident of care, the pharmacy provider must file a claim with the ((~~department~~)) agency consistent with the ((~~department's~~)) agency's billing requirements.

(b) If the private insurer pays the pharmacy provider a monthly capitation fee for all prescription costs related to the client, the pharmacy provider must submit a claim to the ((~~department~~)) agency for the amount of the client copayment, coinsurance, and/or deductible. The ((~~department~~)) agency pays the provider the lesser of:

(i) The billed amount; or

(ii) The ((~~department's~~)) agency's maximum allowable fee for the prescription.

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

WAC 182-530-7900 Drugs purchased under the Public Health Service (PHS) Act. (1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to ((~~medical assistance~~)) Washington apple health clients only by PHS-qualified health facilities and must be billed to the ((~~department~~)) medicaid agency at actual acquisition cost (AAC) as required by laws governing the PHS 340B program.

(2) Providers dispensing drugs under this section are required to submit their valid ((~~medical assistance~~)) medicaid provider number(s) to the PHS health resources and services administration, office of pharmacy affairs. This requirement is to ensure that claims for drugs dispensed under this section and paid by the ((~~department~~)) agency are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs. See WAC ((~~388-530-7500~~)) 182-530-7500 for information on the drug rebate program.

(3) The ((~~department~~)) agency reimburses drugs under this section at actual acquisition cost plus a dispensing fee set by the ((~~department~~)) agency.

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

WAC 182-530-8000 Reimbursement method—Estimated acquisition cost (EAC). (1) The ((~~department~~)) medicaid agency determines estimated acquisition cost (EAC) using:

(a) Acquisition cost data made available to the ((~~department~~)) agency; or

(b) Information provided by any of the following:

(i) Audit agencies, federal or state;

(ii) Other state health care purchasing agencies;

(iii) Pharmacy benefit managers;

(iv) Individual pharmacy providers participating in the ((~~department's~~)) agency's programs;

(v) Centers for Medicare and Medicaid Services (CMS);

(vi) Other third-party payers;

(vii) Drug file data bases; and ((~~/or~~))

(viii) Actuaries or other consultants.

(2) The ((~~department~~)) agency implements EAC by applying a percentage adjustment to available reference pricing from national sources such as wholesale acquisition cost, average wholesale price (AWP), average sale price (ASP), and average manufacturer price (AMP).

(3) The ((~~department~~)) agency may set EAC for specified drugs or drug categories at a maximum allowable cost other than that determined in subsection (1)(a) of this section when the ((~~department~~)) agency considers it necessary. The factors the ((~~department~~)) agency considers in setting a rate for a class of drugs under this subsection include, but are not limited to:

(a) Product acquisition cost;

(b) The ((~~department's~~)) agency's documented clinical concerns; and

(c) The ((~~department's~~)) agency's budget limits.

(4) The ((~~department~~)) agency bases EAC drug reimbursement on the actual package size dispensed.

(5) The ((~~department~~)) agency uses EAC as the ((~~department's~~)) agency's reimbursement for a drug when EAC is the lowest of the rates calculated under the methods listed in WAC ((~~388-530-7000~~)) 182-530-7000, or when the conditions of WAC ((~~388-530-7300~~)) 182-530-7300 are met.

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

WAC 182-530-8050 Reimbursement—Federal upper limit (FUL). (1) The ((~~department~~)) medicaid agency adopts the federal upper limit (FUL) set by the Centers for Medicare and Medicaid Services (CMS).

(2) The ((~~department's~~)) agency's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by the ((~~department~~)) agency.

(3) Except as provided in WAC ((~~388-530-7300~~)) 182-530-7300, the ((~~department~~)) agency uses the FUL as the ((~~department's~~)) agency's reimbursement rate for the drug when the FUL price is the lowest of the rates calculated under the methods listed in WAC ((~~388-530-7000~~)) 182-530-7000.

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

WAC 182-530-8100 Reimbursement—Maximum allowable cost (MAC). (1) The ((~~department~~)) medicaid agency establishes a maximum allowable cost (MAC) for a multiple-source drug which is available from at least two manufacturers/labelers.

(2) The ((~~department~~)) agency determines the MAC for a multiple-source drug:

(a) When specific regional and local drug acquisition cost data is available, the ((~~department~~)) agency:

(i) Identifies what products are available from wholesalers for each drug being considered for MAC pricing;

(ii) Determines pharmacy providers' approximate acquisition costs for these products; and

(iii) Establishes the MAC at a level which gives pharmacists access to at least one product from a manufacturer with a qualified rebate agreement (see WAC ((~~388-530-7500~~)) 182-530-7500(4)).

(b) When specific regional and local drug acquisition cost data is not available, the ((~~department~~)) agency may estimate acquisition cost based on national pricing sources.

(3) The MAC established for a multiple-source drug does not apply if the written prescription identifies that a specific brand is medically necessary for a particular client. In such cases, the estimated acquisition cost (EAC) for the particular brand applies, provided authorization is obtained from the ((~~department~~)) agency as specified under WAC ((~~388-530-3000~~)) 182-530-3000.

(4) Except as provided in subsection (3) of this section, the ((~~department~~)) agency reimburses providers for a multiple-source drug at the lowest of the rates calculated under the methods listed in WAC ((~~388-530-7000~~)) 182-530-7000.

(5) The MAC established for a multiple-source drug may vary by package size, including those identified as unit dose national drug codes (NDCs) by the manufacturer((~~(s)~~)) or manufacturers of the drug.

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

WAC 182-530-8150 Reimbursement—Automated maximum allowable cost (AMAC). (1) The ((~~department~~)) medicaid agency uses the automated maximum allowable cost (AMAC) pricing methodology for multiple-source drugs that are:

(a) Not on the published maximum allowable cost (MAC); and

(b) Produced by two or more manufacturers/labelers, at least one of which must have a current, signed federal drug rebate agreement.

(2) The ((~~department~~)) agency establishes AMAC as a specified percentage of the published average wholesale price (AWP) or other nationally accepted pricing source in order to estimate acquisition cost.

(3) The ((~~department~~)) agency sets the percentage discount from AWP for AMAC reimbursement using any of the information sources identified in WAC ((~~388-530-8000~~)) 182-530-8000.

(4) The ((~~department~~)) agency may set AMAC reimbursement at different percentage discounts from AWP for different multiple source drugs. The ((~~department~~)) agency considers the same factors as those in WAC ((~~388-530-8000~~)) 182-530-8000.

(5) AMAC reimbursement for all products with the same ingredient, form and strength is at the AMAC determined for the second lowest priced product, or the AMAC of the lowest priced drug from a manufacturer with a current, signed federal rebate agreement.

(6) The ((~~department~~)) agency recalculates the AMAC each time the drug file contractor provides a pricing update.

(7) Except as provided in WAC ((~~388-530-7300~~)) 182-530-7300, the ((~~department~~)) agency reimburses at the lowest

of the rates calculated under the methods listed in WAC ((~~388-530-7000~~)) 182-530-7000.

WSR 15-22-057
PROPOSED RULES
DEPARTMENT OF REVENUE
[Filed October 30, 2015, 8:50 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-18-055.

Title of Rule and Other Identifying Information: WAC 458-40-540 Forest land values and 458-40-660 Timber excise tax—Stumpage value tables—Stumpage value adjustments.

Hearing Location(s): Capital Plaza Building, Fourth Floor Executive Conference Room, 1025 Union Avenue S.E., Olympia, WA, on December 8, 2015, at 10:00 a.m. Copies of draft rules are available for viewing and printing on our web site at Rules Agenda.

Call-in option can be provided upon request no later than three days before the hearing date.

Date of Intended Adoption: December 10, 2015.

Submit Written Comments to: Mark E. Bohe, Department of Revenue, Interpretations and Technical Advice Division, P.O. Box 47453, Olympia, WA 98504-7453, e-mail markbohe@dor.wa.gov, fax (360) 534-1606, by December 10, 2015.

Assistance for Persons with Disabilities: Contact Mary Carol LaPalm, (360) 725-7499, or Renee Cosare, (360) 725-7514, no later than ten days before the hearing date. For hearing impaired please contact us via the Washington relay operator at (800) 833-6384.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: RCW 84.33.091 requires the department to revise the stumpage value tables every six months. The department establishes stumpage value tables to apprise timber harvesters of the timber values used to calculate the timber excise tax. The values in the proposed rule will apply to the first half of 2016.

Further, RCW 84.33.140 requires that forest land values be adjusted annually by a statutory formula contained in RCW 84.33.140(3). The department anticipates amending the forest land values rule (WAC 458-40-540) to adjust the table of forest land values in Washington as required by statute. County assessors will use these published land values for property tax purposes in 2016.

Reasons Supporting Proposal: Required by statutes and values needed to calculate timber excise and property taxes.

Statutory Authority for Adoption: RCW 82.32.300, 82.01.060(2), and 84.33.096.

Statute Being Implemented: RCW 84.33.091.

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

Name of Proponent: [Department of revenue], governmental.

Name of Agency Personnel Responsible for Drafting: Mark Bohe, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 534-1574; Implementation and Enforcement: Stuart Thronson, 1025 Union Avenue S.E., Suite #102, Olympia, WA, (360) 534-1300.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No small business economic impact statement is required.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Mark E. Bohe, Interpretations and Technical Advice Division, P.O. Box 47453, Olympia, WA 98504-7453, phone (360) 534-1574, fax (360) 534-1606, e-mail markbohe@dor.wa.gov. The proposed rule is a significant legislative rule as defined by RCW 34.05.328.

October 30, 2015
Kevin Dixon
Rules Coordinator

AMENDATORY SECTION (Amending WSR 15-01-095, filed 12/17/14, effective 1/1/15)

WAC 458-40-540 Forest land values—((~~2015~~)) 2016. The forest land values, per acre, for each grade of forest land for the ((~~2015~~)) 2016 assessment year are determined to be as follows:

LAND GRADE	OPERABILITY CLASS	((~~2015~~)) 2016 VALUES PER ACRE
1	1	$((~~193~~)) 203
	2	((~~191~~)) 201
	3	((~~179~~)) 188
	4	((~~130~~)) 137
2	1	((~~164~~)) 172
	2	((~~158~~)) 166
	3	((~~151~~)) 159
	4	((~~108~~)) 113
3	1	((~~127~~)) 133
	2	((~~123~~)) 129
	3	((~~122~~)) 128
	4	((~~94~~)) 99
4	1	((~~98~~)) 103
	2	((~~95~~)) 100
	3	((~~94~~)) 99
	4	((~~71~~)) 75
5	1	((~~71~~)) 75
	2	((~~63~~)) 66
	3	((~~62~~)) 65
	4	((~~44~~)) 46
6	1	((~~36~~)) 38
	2	((~~34~~)) 36
	3	((~~34~~)) 36
	4	((~~32~~)) 34
7	1	((~~16~~)) 17
	2	((~~16~~)) 17
	3	((~~15~~)) 16
	4	((~~15~~)) 16

LAND GRADE	OPERABILITY CLASS	((2015)) 2016 VALUES PER ACRE
8	1	1

AMENDATORY SECTION (Amending WSR 15-14-019, filed 6/22/15, effective 7/1/15)

WAC 458-40-660 Timber excise tax—Stumpage value tables—Stumpage value adjustments. (1) **Introduction.** This rule provides stumpage value tables and stumpage value adjustments used to calculate the amount of a harvester's timber excise tax.

(2) **Stumpage value tables.** The following stumpage value tables are used to calculate the taxable value of stumpage harvested from ((July 1 through December 31, 2015)) January 1 through June 30, 2016:

Washington State Department of Revenue
STUMPAGE VALUE TABLE
((July 1 through December 31, 2015))
January 1 through June 30, 2016
Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]
Starting July 1, 2012, there are no separate
Quality Codes per Species Code.

Species Name	Species Code	SVA (Stumpage Value Area)	Haul Zone 1	2	3	4	5
((Douglas-fir[2]	DF	1	$463	$456	$449	$442	$435
		2	485	478	471	464	457
		3	457	450	443	436	429
		4	527	520	513	506	499
		5	474	467	460	453	446
		6	282	275	268	261	254
Western Hemlock and	WH	1	312	305	298	291	284
Other Conifer[3]		2	363	356	349	342	335
		3	374	367	360	353	346
		4	359	352	345	338	331
		5	354	347	340	333	326
		6	260	253	246	239	232
Western Redcedar[4]	RC	1-5	963	956	949	942	935
		6	704	697	690	683	676
Ponderosa Pine[5]	PP	1-6	232	225	218	211	204
Red Alder	RA	1-5	492	485	478	471	464
Black Cottonwood	BC	1-5	80	73	66	59	52
Other Hardwood	OH	1-5	338	331	324	317	310
		6	32	25	18	11	1
Douglas-fir Poles & Piles	DFL	1-5	879	872	865	858	851
Western Redcedar Poles	RCL	1-5	1522	1515	1508	1501	1494
		6	953	946	939	932	925
Chipwood[6]	CHW	1-5	10	9	8	7	6
		6	4	3	2	1	1
Small Logs[6]	SML	6	24	23	22	21	20
RC Shake & Shingle Blocks[7]	RCS	1-6	289	282	275	268	261
Posts[8]	LPP	1-6	0.35	0.35	0.35	0.35	0.35
DF Christmas Trees[9]	DFX	1-6	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[9]	TFX	1-6	0.50	0.50	0.50	0.50	0.50))
Douglas-fir(2)	DF	1	$423	$416	$409	$402	$395
		2	459	452	445	438	431
		3	482	475	468	461	454
		4	506	499	492	485	478
		5	429	422	415	408	401
		6	307	300	293	286	279
Western Hemlock and	WH	1	266	259	252	245	238
Other Conifer(3)		2	323	316	309	302	295
		3	310	303	296	289	282
		4	289	282	275	268	261
		5	280	273	266	259	252
		6	260	253	246	239	232
Western Redcedar(4)	RC	1-5	958	951	944	937	930
		6	783	776	769	762	755
Ponderosa Pine(5)	PP	1-6	240	233	226	219	212
Red Alder	RA	1-5	476	469	462	455	448
Black Cottonwood	BC	1-5	86	79	72	65	58
Other Hardwood	OH	1-5	328	321	314	307	300
		6	32	25	18	11	4
Douglas-fir Poles & Piles	DFL	1-5	817	810	803	796	789
Western Redcedar Poles	RCL	1-5	1544	1537	1530	1523	1516
		6	1026	1019	1012	1005	998
Chipwood(6)	CHW	1-5	12	11	10	9	8
		6	4	3	2	1	1
Small Logs(6)	SML	6	25	24	23	22	21
RC Shake & Shingle Blocks(7)	RCS	1-6	289	282	275	268	261
Posts(8)	LPP	1-6	0.35	0.35	0.35	0.35	0.35
DF Christmas Trees(9)	DFX	1-6	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees(9)	TFX	1-6	0.50	0.50	0.50	0.50	0.50

(1) Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.

(2) Includes Western Larch.

(3) Includes all Hemlock, Spruce and true Fir species, Lodgepole Pine in SVA 6, or any other conifer not listed on this page.

(4) Includes Alaska-Cedar.

(5) Includes Western White Pine in SVA 6, and all Pines in SVA 1-5.
(6) Stumpage value per ton.
(7) Stumpage value per cord.
(8) Includes Lodgepole posts and other posts, Stumpage Value per 8 lineal feet or portion thereof.
(9) Stumpage Value per lineal foot.

(3) **Harvest value adjustments.** The stumpage values in subsection (2) of this rule for the designated stumpage value areas are adjusted for various logging and harvest conditions, subject to the following:

(a) No harvest adjustment is allowed for special forest products, chipwood, or small logs.

(b) Conifer and hardwood stumpage value rates cannot be adjusted below one dollar per MBF.

(c) Except for the timber yarded by helicopter, a single logging condition adjustment applies to the entire harvest unit. The taxpayer must use the logging condition adjustment class that applies to a majority (more than 50%) of the acreage in that harvest unit. If the harvest unit is reported over more than one quarter, all quarterly returns for that harvest unit must report the same logging condition adjustment. The helicopter adjustment applies only to the timber volume from the harvest unit that is yarded from stump to landing by helicopter.

(d) The volume per acre adjustment is a single adjustment class for all quarterly returns reporting a harvest unit. A harvest unit is established by the harvester prior to harvesting. The volume per acre is determined by taking the volume logged from the unit excluding the volume reported as chipwood or small logs and dividing by the total acres logged. Total acres logged does not include leave tree areas (RMZ, UMZ, forested wetlands, etc.,) over 2 acres in size.

(e) A domestic market adjustment applies to timber which meet the following criteria:

(i) **Public timber** - Harvest of timber not sold by a competitive bidding process that is prohibited under the authority of state or federal law from foreign export may be eligible for the domestic market adjustment. The adjustment may be applied only to those species of timber that must be processed domestically. According to type of sale, the adjustment may be applied to the following species:

Federal Timber Sales: All species except Alaska-cedar. (Stat. Ref. - 36 C.F.R. 223.10)

State, and Other Nonfederal, Public Timber Sales: Western Redcedar only. (Stat. Ref. - 50 U.S.C. appendix 2406.1)

(ii) **Private timber** - Harvest of private timber that is legally restricted from foreign export, under the authority of The Forest Resources Conservation and Shortage Relief Act (Public Law 101-382), (16 U.S.C. Sec. 620 et seq.); the Export Administration Act of 1979 (50 U.S.C. App. 2406(i)); a Cooperative Sustained Yield Unit Agreement made pursuant to the act of March 29, 1944 (16 U.S.C. Sec. 583-583i); or Washington Administrative Code (WAC 240-15-015(2)) is also eligible for the Domestic Market Adjustment.

The following harvest adjustment tables apply from ((~~July 1 through December 31, 2015~~)) January 1 through June 30, 2016:

TABLE 9—Harvest Adjustment Table
Stumpage Value Areas 1, 2, 3, 4, and 5
((~~July 1 through December 31, 2015~~))
January 1 through June 30, 2016

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
I. Volume per acre		
Class 1	Harvest of 30 thousand board feet or more per acre.	$0.00
Class 2	Harvest of 10 thousand board feet to but not including 30 thousand board feet per acre.	-$15.00
Class 3	Harvest of less than 10 thousand board feet per acre.	-$35.00
II. Logging conditions		
Class 1	Ground based logging a majority of the unit using tracked or wheeled vehicles or draft animals.	$0.00
Class 2	Cable logging a majority of the unit using an overhead system of winch driven cables.	-$85.00
Class 3	Applies to logs yarded from stump to landing by helicopter. This does not apply to special forest products.	-$145.00
III. Remote island adjustment:		
	For timber harvested from a remote island	-$50.00
IV. Thinning		
Class 1	A limited removal of timber described in WAC 458-40-610 (28)	-$100.00

TABLE 10—Harvest Adjustment Table
Stumpage Value Area 6
((~~July 1 through December 31, 2015~~))
January 1 through June 30, 2016

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
I. Volume per acre		
Class 1	Harvest of more than 8 thousand board feet per acre.	$0.00
Class 2	Harvest of 8 thousand board feet per acre and less.	-$8.00
II. Logging conditions		
Class 1	The majority of the harvest unit has less than 40% slope. No significant rock outcrops or swamp barriers.	$0.00
Class 2	The majority of the harvest unit has slopes between 40% and 60%. Some rock outcrops or swamp barriers.	-$50.00
Class 3	The majority of the harvest unit has rough, broken ground with slopes over 60%. Numerous rock outcrops and bluffs.	-$75.00
Class 4	Applies to logs yarded from stump to landing by helicopter. This does not apply to special forest products.	-$145.00

Type of Adjustment	Definition	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale

Note: A Class 2 adjustment may be used for slopes less than 40% when cable logging is required by a duly promulgated forest practice regulation. Written documentation of this requirement must be provided by the taxpayer to the department of revenue.

III. Remote island adjustment:

	For timber harvested from a remote island	-$50.00

TABLE 11—Domestic Market Adjustment

Class	Area Adjustment Applies	Dollar Adjustment Per Thousand Board Feet Net Scribner Scale
	SVAs 1 through 5 only:	$0.00

Note: This adjustment only applies to published MBF sawlog values.

(4) **Damaged timber.** Timber harvesters planning to remove timber from areas having damaged timber may apply to the department of revenue for an adjustment in stumpage values. The application must contain a map with the legal descriptions of the area, an accurate estimate of the volume of damaged timber to be removed, a description of the damage sustained by the timber with an evaluation of the extent to which the stumpage values have been materially reduced from the values shown in the applicable tables, and a list of estimated additional costs to be incurred resulting from the removal of the damaged timber. The application must be received and approved by the department of revenue before the harvest commences. Upon receipt of an application, the department of revenue will determine the amount of adjustment to be applied against the stumpage values. Timber that has been damaged due to sudden and unforeseen causes may qualify.

(a) Sudden and unforeseen causes of damage that qualify for consideration of an adjustment include:

(i) Causes listed in RCW 84.33.091; fire, blow down, ice storm, flood.

(ii) Others not listed; volcanic activity, earthquake.

(b) Causes that do not qualify for adjustment include:

(i) Animal damage, root rot, mistletoe, prior logging, insect damage, normal decay from fungi, and pathogen caused diseases; and

(ii) Any damage that can be accounted for in the accepted normal scaling rules through volume or grade reductions.

(c) The department of revenue will not grant adjustments for applications involving timber that has already been harvested but will consider any remaining undisturbed damaged timber scheduled for removal if it is properly identified.

(d) The department of revenue will notify the harvester in writing of approval or denial. Instructions will be included for taking any adjustment amounts approved.

(5) **Forest-derived biomass,** has a $0/ton stumpage value.

WSR 15-22-066
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 2, 2015, 9:49 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-17-112.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-478-0015 Need standards for cash assistance, to revise the basic need standards for cash assistance.

Hearing Location(s): Office Building 2, DSHS Headquarters, 1115 Washington, Olympia, WA 98504 (public parking at 11th and Jefferson. A map is available at http://www1.dshs.wa.gov/msa/rpau/RPAU-OB-2directions.html), on December 8, 2015, at 10:00 a.m.

Date of Intended Adoption: Not earlier than December 9, 2015.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, e-mail DSHSRPAURulesCoordinator@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. December 8, 2015.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, by November 24, 2015, phone (360) 664-6092 or TTY (360) 664-6178, e-mail KildaJA@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The community services division is proposing to amend WAC 388-478-0015 in order to revise the basic need standards for cash assistance programs.

Reasons Supporting Proposal: DSHS is required by RCW 74.04.770 to establish standards of need for cash assistance programs on an annual basis.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090.

Statute Being Implemented: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090.

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

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

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Leslie Kozak, P.O. Box 45470, Olympia, WA 98504-5470, (360) 725-4589.

No small business economic impact statement has been prepared under chapter 19.85 RCW. These proposed rules do not have an economic impact on small businesses. The proposed amendment only affects DSHS clients by revising the need standards for cash assistance.

A cost-benefit analysis is not required under RCW 34.05.328. These amendments are exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in-part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents." This rule affects the need standards for cash assistance as outlined in WAC 388-478-0015.

October 30, 2015
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-24-072, filed 11/26/14, effective 1/1/15)

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	$((~~1,254~~)) 1,308
2	((~~1,587~~)) 1,656
3	((~~1,959~~)) 2,044
4	((~~2,312~~)) 2,412
5	((~~2,664~~)) 2,780
6	((~~3,017~~)) 3,148
7	((~~3,487~~)) 3,638
8	((~~3,859~~)) 4,027
9	((~~4,231~~)) 4,415
10 or more	((~~4,604~~)) 4,803

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$((~~632~~)) 665
2	((~~799~~)) 842
3	((~~987~~)) 1,039
4	((~~1,165~~)) 1,226
5	((~~1,342~~)) 1,413
6	((~~1,520~~)) 1,600
7	((~~1,757~~)) 1,849
8	((~~1,944~~)) 2,047
9	((~~2,132~~)) 2,244
10 or more	((~~2,319~~)) 2,442

WSR 15-22-074
PROPOSED RULES
DEPARTMENT OF HEALTH
(Board of Naturopathy)
[Filed November 2, 2015, 2:25 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 13-21-028.

Title of Rule and Other Identifying Information: WAC 246-836-080 Continuing competency program, amending continuing competency requirements for naturopathic physicians to clarify completion frequency and deadlines, and to include suicide prevention training.

Hearing Location(s): Department of Health, Town Center 2 (TC2), Room 145, 111 Israel Road S.E., Tumwater, WA 98501, on December 18, 2015, at 1:00 p.m.

Date of Intended Adoption: December 18, 2015.

Submit Written Comments to: Susan Gragg, Program Manager, Department of Health, P.O. Box 47852, Olympia, WA 98504-7852, e-mail http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by December 10, 2015.

Assistance for Persons with Disabilities: Contact Susan Gragg by December 4, 2015, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The board of naturopathy (board) had begun rule making to update existing continuing education (CE) rules when the legislature passed chapter 71, Laws of 2014 (ESHB 2315). This bill requires naturopathic physicians (among other professions) to complete a one-time, six-hour training in suicide assessment, treatment, and management. The board believes the suicide prevention training requirement should take precedence over the original work on CE and has decided to move forward with implementing ESHB 2315. Chapter 249, Laws of 2015 (SHB [ESHB] 1424) revised the requirement date and the proposed rule incorporates that change as well. Two additional amendments clarify that CE is required yearly and when it must be completed in relation to the license renewal cycle. The board will address the remainder of the CE updates in a future rule project.

Reasons Supporting Proposal: ESHB 2315 added eleven health care professions, including naturopathic physicians, to the list of professions in RCW 43.70.422 that are required to complete training in suicide assessment, treatment, and management. The legislature's intent in requiring such training is to help lower the suicide rate in Washington state.

Statutory Authority for Adoption: RCW 18.36A.160.

Statute Being Implemented: RCW 43.70.442 as amended by chapter 71, Laws of 2014.

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

Name of Proponent: Board of naturopathy, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Susan Gragg, Program Manager, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4941.

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 Susan Gragg, Department of Health, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-4941, fax (360) 236-2901, e-mail susan.gragg@doh.wa.gov.

November 2, 2015
Chris Humberson, R.Ph.
Executive Director

AMENDATORY SECTION (Amending WSR 12-13-104, filed 6/20/12, effective 7/21/12)

WAC 246-836-080 Continuing competency program. (1) Each licensed naturopathic physician((~~s~~)) must ((~~demonstrate completion of~~)) complete twenty hours of continuing education per year, as provided in chapter 246-12 WAC, Part 7. ((~~Only courses in diagnosis and therapeutics as listed in RCW 18.36A.040 shall be eligible for credit.~~))

(2) A license holder's first twenty hour continuing education requirement is due on the second renewal date after the license is issued. After that, it is due annually on the renewal date.

(3) As part of continuing education, a licensed naturopathic physician must complete a board-approved one-time training that is at least six hours long in suicide assessment, treatment, and management. This training must be completed by the end of the first full continuing education reporting period after January 1, 2016, or the first full continuing education reporting period after initial licensure, whichever is later.

(a) Until July 1, 2017, a board-approved training must be an empirically supported training in suicide assessment, including screening and referral, suicide treatment, and suicide management, and meet any other requirement in RCW 43.70.442.

(b) Beginning July 1, 2017, training accepted by the board must be on the department's model list developed in accordance with rules adopted by the department that establish minimum standards for training programs. The establishment of the model list does not affect the validity of training completed prior to July 1, 2017.

(c) A board-approved training must be at least six hours in length and may be provided in one or more sessions.

(d) The hours spent completing the training in suicide assessment, treatment, and management under this subsection count toward meeting any applicable continuing education requirements.

(e) Nothing in this subsection is intended to expand or limit the naturopathic scope of practice.

(4) In emergency situations, such as personal or family illness, the board may in its discretion, for good cause shown, waive all or part of the continuing education requirement for a particular one year period for an individual licensee. The board may require such verification of the emergency as is necessary to prove its existence.

WSR 15-22-076
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed November 2, 2015, 4:33 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 14-15-103.

Title of Rule and Other Identifying Information: WAC 246-830-037 Transfer of training hours, the department of health (DOH) is proposing a new section be added to existing massage rules regarding transfer of training hours for massage students.

Hearing Location(s): Washington Department of Health, Point Plaza East, Room 152, 310 Israel Road S.E., Tumwater, WA 98504, on December 17, 2015, at 1:30 p.m.

Date of Intended Adoption: December 23, 2015.

Submit Written Comments to: Megan Brown, P.O. Box 47852, Olympia, WA 98504-7852, e-mail http://www3.doh.wa.gov/policyreview/, fax (360) 236-2901, by December 17, 2015.

Assistance for Persons with Disabilities: Contact Cece Zenker at (360) 236-4633 by December 10, 2015, 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 clarify that all applicants for massage practitioner licensure must successfully complete an entire course of study from a board of massage (board) approved program or programs to qualify for a license per RCW 18.108.070. The anticipated effect is that the secretary will only issue a license to qualified applicants, which will provide greater protection to the public's health and safety.

Reasons Supporting Proposal: The proposed rule is consistent with the requirements of chapter 18.108 RCW and a recent ruling by a health law judge. Over the past several years many massage applicants transferred hours from an unapproved massage school to a board approved school. Department investigations found many of these applicants admitted having insufficient education and buying fake transcripts and the answers to the national exam. In a recent disciplinary case, the massage program denied a transfer applicant a license based on failure to meet education requirements. The health law judge upheld program's action.

Statutory Authority for Adoption: RCW 18.108.025 and 18.108.085.

Statute Being Implemented: RCW 18.108.070.

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

Name of Proponent: DOH, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Megan Brown, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-4945.

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

Small Business Economic Impact Statement

Describe the proposed rule, including: A brief history of the issue; an explanation of why the proposed rule is needed; and a brief description of the probable compliance requirements and the kinds of professional services that a small business is likely to need in order to comply with the proposed rule.

DOH is proposing a new section to chapter 246-830 WAC to clarify existing language in RCW 18.108.070 (1)(a). The proposed language states that applicants seeking a massage practitioner license must obtain their entire training and education from a program(s) approved by the Washington state board of massage (board). The proposed rule will eliminate confusion amongst schools, applicants, and the depart-

ment about the licensure qualifications. The proposed rule is needed to:

- Clarify the language in statute that "course of study in an approved massage program" means an entire board-approved program.
- Avoid the practice of approved massage schools to counting transfer students' hours from a nonboard-approved school to meet Washington's education requirements, and ensure that the board's authority for approving massage programs is not usurped.

History: Applicants for a massage license may pursue licensure through two avenues.

1. Demonstrating to the secretary's satisfaction that they have successfully completed a course of study in a board-approved massage or apprenticeship program. (RCW 18.108.070)

2. Holding a current license to practice massage in another jurisdiction that has examination and education requirements substantially equivalent to those in Washington. (RCW 18.108.095)

Over time, some board-approved massage schools created "bridge programs" for students who received their education at a nonboard-approved school. In such cases, the board-approved school evaluated the student's transcripts and created a condensed program for the student to complete in order to meet Washington's minimum training requirements. In many cases, the student did not complete any training hours at the board-approved school but rather paid a fee for the school to attest that the student met all training requirements and issue the student a diploma.

Multiple DOH investigations have been conducted on applicants who completed a bridge program and transferred their hours from a blacklisted school (blacklisted schools have been identified by the National Certification Board for Therapeutic Massage and Bodywork and/or the California Massage Therapy Council if the school is found to have been operating illegitimately). The investigations have found that the majority of these applicants admit to:

- Receiving minimal if any education and training.
- Paying hundreds or thousands of dollars for counterfeit transcripts and diplomas.
- Paying for and receiving the answers to a national exam that is required for licensure.

In February 2015, a health law judge upheld the department's decision to deny an applicant a massage license based on not meeting the education and training requirements. The final order went on to say that the applicant must satisfactorily complete an entire course of study at any board-approved program.

A brief description of the probable compliance requirements: The majority of board-approved schools only offer a full program. The proposed rule would have no effect on such schools.

There are only a handful of schools that offer a transfer option. Additionally, these schools have full board-approved programs. Schools that accept transfer hours would have compliance requirements to include:

- Change its transfer program requirements to only offer the program to students that have received some of their education at a board-approved school.
- Change any advertisements, course syllabi, etc. that may indicate a person can transfer any previous educational hours.
- Be responsible about knowing which schools are/have been board-approved and train staff accordingly.

Identify which businesses are required to comply with the proposed rule using the North American Industry Classification System (NAICS) codes and what the minor cost thresholds are.

Table A:

NAICS Code (4, 5 or 6 digit)	NAICS Business Description	# of Businesses in WA	Minor Cost Threshold = 1% of Average Annual Payroll	Minor Cost Threshold = .3% of Average Annual Receipts
611519	Other Technical and Trade Schools (Includes Massage Instruction)	62	1% payroll = $3,284.72	Not available

Analyze the probable cost of compliance. Identify the probable costs to comply with the proposed rule, including: Cost of equipment, supplies, labor, professional services and increased administrative costs; and whether compliance with the proposed rule will cause businesses to lose sales or review [revenue].

To gauge the impact of the proposed rule, the department staff surveyed nine board-approved massage schools. This survey asked the schools to identify the estimated impact of the proposed change of requiring applicants to receive all of the education and training in a board-approved school. The survey asked the schools to provide specific estimates for:

1. To identify what kinds of things (i.e., administrative, supplies, training, etc.) they may have to change to comply with the proposed rule and to estimate the probable costs for small businesses to comply with the proposed rule.

2. How schools calculate the cost they charge to students (i.e., flat rate, by number of credits, other).

3. How much the school charged students using the bridge program (transfer program).

4. Do they foresee any increase or decrease in student enrollment (would transfer students be likely to enroll in the full program?).

Department staff received survey responses from four schools. Schools indicated that the tuition for transfer stu-

dents ranged from $475 to $800. This fee covered administration costs (reviewing files, interviews, hands-on evaluation, recordkeeping/paperwork, etc.). If the student needs additional training hours, the fees were approximately $20 per hour. None of the respondents indicated that they believed they would see an increase in the number of students due to the rule change. One respondent indicated that they would likely lose a number of students that currently transfer from another university. Schools indicated that they would incur nominal costs to make administrative changes to their program (web site, printed materials, etc.) to reflect the proposed rule.

Analyze whether compliance with the proposed rule will cause businesses to lose sales or revenue.

Schools that accept transfer hours may see an initial loss in revenue because they will no longer be able to accept credits from transfer students from unapproved schools. The actual amount of "lost sales" is indeterminable.

The department's assumption is that schools are aware that this change is coming in rule and are already taking steps to minimize their revenue loss.

Analyze whether the proposed rule may impose more than minor costs on businesses in the industry.

The department is unable to estimate the probable cost of the proposed rule. The survey indicated that the schools would incur "administration costs" associated with changing curriculum, advertisements, course handouts, etc .... In addition to the administrative costs, some schools did indicate that they would lose revenue due to not accepting credits from transfer students from unapproved schools but again, this amount is indeterminable. In the first year some schools may see a decrease in revenue as a result of students who choose not to enroll in a full program. Board-approved schools have been advised of the health law judge's ruling and are taking steps to address this loss of revenue.

There is a possibility for some approved schools to see an increase in revenue, based on bridge student enrollment. Due to this uncertainty the department, for the purposes of this analysis, assumes that the rule will result in two or more massage schools incurring costs that exceed the minor cost threshold calculated at $3,284.72.

Determine whether the proposed rule may have a disproportionate impact on small businesses as compared to the ten percent of businesses that are the largest businesses required to comply with the proposed rule.

As stated above, the rule will likely result in a reduction of revenue from students that will not be allowed to transfer credits from unapproved schools. The department assumes that the rule will also likely have a disproportionate impact on small businesses. Although the proposed rule may initially have a disproportionate impact on the small business [businesses] that offer a transfer program or accept transfer hours, these schools will still be able to offer a transfer program to a number of students who meet certain criteria (i.e., hours already obtained at a board-approved school). The majority of the larger schools won't see much if any impact. Most of them do not offer a transfer option.

The department determined there are no mitigating options available. The rule clarifies what is already in law consistent with the health law judge's ruling.

Describe how small businesses were involved in the development of the proposed rule.

Small businesses that offer transfer option[s] have been very involved in attending board meetings and participating in rule discussion. All board-approved schools were notified of the health law judge's ruling and the department's action based on the order. Furthermore, the department surveyed schools that used the transfer option. The survey questions informed the schools about the potential impact of the rule.

Identify the estimated number of jobs that will be created or lost as the result of compliance with the proposed rule.

Staff worked closely with constituents and the public to minimize the burden of this rule. Compliance with the rule should not require the creation or loss of jobs.

A copy of the statement may be obtained by contacting Megan Brown, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-4945, fax (360) 236-2901, e-mail megan.brown@doh.wa.gov.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Megan Brown, P.O. Box 47852, Olympia, WA 98504-7852, phone (360) 236-4945, fax (360) 236-2901, e-mail megan.brown@doh.wa.gov.

November 2, 2015

John Wiesman, DrPH, MPH

Secretary

NEW SECTION

WAC 246-830-037 Transfer of training hours. The secretary shall only grant a license to an applicant seeking initial licensure under WAC 246-830-020 who completes their entire course of study through a massage program or programs approved by the Washington state board of massage.

WSR 15-22-088

WITHDRAWL OF PROPOSED RULES

GAMBLING COMMISSION

(By the Code Reviser's Office)

[Filed November 3, 2015, 10:11 a.m.]

WAC 230-06-030, 230-06-031 and 230-15-453, proposed by the gambling commission in WSR 15-09-076, appearing in issue 15-09 of the Washington State Register, which was distributed on May 6, 2015, 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 15-22-089
WITHDRAWL OF PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION
[Filed November 3, 2015, 10:17 a.m.]

WAC 392-123-095, 392-127-004, 392-127-006, 392-127-015, 392-127-045, 392-127-065, 392-127-070, 392-127-075, 392-127-080, 392-127-085, 392-127-090, 392-127-111 and 392-127-112, proposed by the superintendent of public instruction in WSR 15-09-140, appearing in issue 15-09 of the Washington State Register, which was distributed on May 6, 2015, 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 15-22-098
PROPOSED RULES
DEPARTMENT OF FISH AND WILDLIFE
[Filed November 3, 2015, 3:29 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-18-114 on September 2, 2015.

Title of Rule and Other Identifying Information: WAC 220-55-180 Point-of-sale transaction fee.

Hearing Location(s): Northwest Maritime Center, 431 Water Street, Port Townsend, WA 98368, on December 11-12, 2015, at 8:30 a.m.

Date of Intended Adoption: On or after December 11, 2015.

Submit Written Comments to: Joanna Eide, WDFW Rules Coordinator, 600 Capitol Way North, Olympia, WA 98501-1091, e-mail Rules.Coordinator@dfw.wa.gov, fax (360) 902-2155, by December 4, 2015.

Assistance for Persons with Disabilities: Contact Tami Lininger by December 4, 2015, TTY (800) 833-6388 or (360) 902-2267.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is considering changes to WAC 220-55-180 to align the WAC language to allow for the use of transaction fee funds as provided in RCW 77.32.050.

Reasons Supporting Proposal: RCW 77.32.050 states that a transaction fee on commercial and recreational license documents issued through an automated licensing system may be set by the fish and wildlife commission and collected from licensees. RCW 77.32.050 also provides that the department may authorize all or part of such fee to be paid directly to a contractor providing automated licensing services. The department sets this transaction fee in WAC 220-55-180. The department is considering changes to WAC 220-55-180 to align the WAC language to allow for the use of transaction fee funds as provided in RCW 77.32.050.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.055, 77.12.047, and 77.32.050.

Statute Being Implemented: RCW 77.04.012, 77.04.055, 77.12.047, and 77.32.050.

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

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Additional information on the fish and wildlife commission meeting where the public hearing on this rule making will be held is available here http://wdfw.wa.gov/commission/meetings.html.

Name of Proponent: Washington department of fish and wildlife, governmental.

Name of Agency Personnel Responsible for Drafting: Joanna Eide, 1111 Washington Street S.E., Olympia, WA 98501, (360) 902-2403; Implementation: Joe Stohr, 1111 Washington Street S.E., Olympia, WA 98501, (360) 902-2650; and Enforcement: Steve Crown, 1111 Washington Street S.E., Olympia, WA 98501, (360) 902-2373.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This rule making does not make changes to the fee amount or the collection of the fee; rather, it proposes changes to how the department uses the transaction fee after its collection. For this reason, this rule making will not have any impacts to small business as it is an internal administrative change.

A cost-benefit analysis is not required under RCW 34.05.328. This proposal does not involve hydraulics rules which are the only rules in WDFW's administrative code that are considered significant legislative rules that would require s [a] cost-benefit analysis under RCW 34.05.328.

November 3, 2015
Joanna M. Eide
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-22-002, filed 10/19/11, effective 11/19/11)

WAC 220-55-180 Point-of-sale transaction fee. The point-of-sale transaction fee shall be used to operate an automated licensing system or for other uses that support providing fish and wildlife related opportunities, customer service, and enhanced experiences for department license holders. This fee shall be applied to all automated licensing system purchases of recreational and commercial documents. The transaction fee shall be ten percent of the value of the document transaction, excluding any applicable dealer fees.

WSR 15-22-101
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed November 4, 2015, 8:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-17-003.

Title of Rule and Other Identifying Information: New chapter 82-75 WAC, All payer health care claims data base.

Hearing Location(s): Office of Financial Management (OFM), Insurance Building, 302 Sid Snyder Avenue S.W., Conference Room 440, Olympia, WA 98501, on December 17, 2015, at 9:00 a.m.

Date of Intended Adoption: January 5, 2016.

Submit Written Comments to: Susan Meldazy, OFM, P.O. Box 43113, Olympia, WA 98504-3113, e-mail apcd@ofm.wa.gov, fax (360) 664-2832, by December 15, 2015.

Assistance for Persons with Disabilities: Contact OFM by December 14, 2015, TTY (360) 753-4107 or (360) 902-3092.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Chapter 43.371 RCW directs OFM to establish a statewide all payer health care claims data base to support transparent public reporting of health care information. Chapter 43.371 RCW, as amended by ESSB 5084, Sections 1, 5 and 7 provides that the OFM director shall adopt rules necessary to implement this chapter and provides specific areas in which rules should be adopted.

These new rules create the required definitions and additional definitions. The rules set the registration requirements, data submission schedule, historical data submission, data submission guide, standard and process for waivers and extensions, penalties for failure to comply with reporting requirements, administrative review and appeals.

These rules begin to set the requirements necessary to implement the all payer health care claims data base.

Reasons Supporting Proposal: The proposed new rules implement chapter 43.371 RCW.

Statutory Authority for Adoption: Chapter 43.371 RCW.

Statute Being Implemented: Chapter 43.371 RCW.

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

Name of Proponent: OFM, governmental.

Name of Agency Personnel Responsible for Drafting: Roselyn Marcus, 302 Sid Snyder Avenue S.W., Olympia, WA 98501, (360) 902-0434; Implementation and Enforcement: Thea Mounts, General Administration Building, Olympia, Washington 98501, (360) 902-0552.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The rules do not have an impact to small businesses, as that term is defined in statute.

A cost-benefit analysis is not required under RCW 34.05.328. These rules are not significant legislative rules, as defined in statute. These rules are not subject to this requirement.

November 3, 2015
Roselyn Marcus
Assistant Director of Legal
and Legislative Affairs

Chapter 82-75 WAC

ALL PAYER HEALTH CARE CLAIMS DATA BASE

NEW SECTION

WAC 82-75-010 Purpose. (1) Chapter 43.371 RCW establishes the framework for the creation and administration of a statewide all-payer health care claims data base.

(2) RCW 43.371.020 directs the office of financial management to establish a statewide all-payer health care claims data base to support transparent public reporting of health care information. The office shall select a lead organization to coordinate and manage the data base. The lead organization shall also contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics.

(3) RCW 43.371.070 mandates that the director of the office of financial management adopt rules necessary to implement chapter 43.371 RCW. In addition, RCW 43.371.-010 and 43.371.050 direct the adoption of specific rules by the director.

(4) The purpose of this chapter is to implement chapter 43.371 RCW, to facilitate the creation and administration of the Washington statewide all-payer health care claims data base.

NEW SECTION

WAC 82-75-020 Definitions required by chapter 43.371 RCW. The following definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Allowed amount" means the maximum dollar amount contractually agreed to for an eligible health care service covered under the terms of an insurance policy, health benefits plan or state labor and industries program.

"Billed amount" means the dollar amount charged for a health care service rendered.

"Claim file" means a data set composed of health care service level remittance information for all nondenied adjudicated claims under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, covered medical services files, pharmacy files and dental files.

"Covered medical services file" means a data set composed of service level remittance information for all nondenied adjudicated claims for Washington covered persons that are authorized under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, member demographics, provider information, charge and payment information including facility fees, clinical diagnosis codes and procedure codes.

"Data file" means a data set composed of member or provider information including, but not limited to, member eligibility and enrollment data and provider data with necessary identifiers.

"Dental claims file" means a data set composed of service level remittance information for all nondenied adjudicated claims for dental services for Washington covered persons including, but not limited to, member demographics, provider information, charge and payment information

including facility fees, and current dental terminology codes as defined by the American Dental Association.

"Member eligibility and enrollment data file" means a data set containing data about Washington covered persons who receive health care coverage from a payer for one or more days of coverage during the reporting period including, but not limited to, subscriber and member identifiers, member demographics, plan type, benefit codes, and enrollment start and end dates.

"Paid amount" means the actual dollar amount paid for a health care service rendered under the terms of an insurance policy, health benefits plan or state labor and industries program for covered services, excluding member copayments, coinsurance, deductibles and other sources of payment.

"Pharmacy claims file" means a data set containing service level remittance information for all nondenied adjudicated claims for pharmacy services for Washington covered persons including, but not limited to, enrolled member demographics, provider information, charge and payment information including dispensing fees, and national drug codes.

"Provider data with necessary identifiers" means a data file containing information about health care providers that submitted claims for providing health care services, equipment or supplies, to subscribers or members and such other data as required by the data submission guide.

NEW SECTION

WAC 82-75-030 Additional definitions authorized by chapter 43.371 RCW. The following additional definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Claim" means a request or demand on a carrier for payment of a benefit.

"Coinsurance" means the percentage or amount an enrolled member pays towards the cost of a covered service.

"Copayment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

"Data submission guide" means the document that contains data submission requirements including, but not limited to, required fields, file layouts, file components, edit specifications, instructions and other technical specifications.

"Deductible" means the total dollar amount an enrolled member pays on an incurred claim toward the cost of specified covered services designated by the policy or plan over an established period of time before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.

"Director" means the director of the office of financial management.

"Health benefits plan" or "health plan" has the same meaning as in RCW 48.43.005.

"Health care" means care, services, or supplies related to the prevention, cure or treatment of illness, injury or disease of an individual, which includes medical, pharmaceutical or dental care. Health care includes, but is not limited to:

(a) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(b) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

"Lead organization" means the entity selected by the office of financial management to coordinate and manage the data base as provided in chapter 43.371 RCW.

"Member" means the insured subscriber and any spouse or dependent or both who are covered by the subscriber's policy.

"Office" means the Washington state office of financial management.

"Subscriber" means the insured individual who pays the premium or whose employment makes him or her eligible for coverage under an insurance policy or member of a health benefit plan.

"WA-APCD" means the statewide all payer health care claims data base authorized in chapter 43.371 RCW.

"Washington covered person" means any eligible member and all covered dependents where the state of Washington has primary jurisdiction, and whose laws, rules and regulations govern the members' and dependents' insurance policy or health benefit plan.

NEW SECTION

WAC 82-75-040 Registration requirements. (1) **Initial registration.** Each data supplier required to submit health care data pursuant to chapter 43.371 RCW shall register within thirty days of notification from the lead organization.

(2) **Annual registration.** Each data supplier required to submit health care data pursuant to chapter 43.371 RCW shall register by December 31st of each year after the initial registration. If the data supplier initially registers September 1st or later, then the data supplier shall file its annual registration by December 31st of the year following the year of the initial registration.

(3) Each data supplier newly required to submit health care data under chapter 43.371 RCW, either by a change in law or loss of qualified exemption, shall register with the lead organization within thirty days of being required to submit data.

NEW SECTION

WAC 82-75-050 Data submission schedule. (1) Data suppliers shall submit the required health care data in accordance with the schedule provided in this section.

(2) **Test file.**

(a) At least sixty calendar days prior to the data suppliers' first required submission, the lead organization will notify the data supplier in writing regarding the obligation to file. The lead organization will schedule time to work with the data supplier to establish a schedule for when the data supplier shall submit the initial test files.

(b) No more than ninety calendar days after notification of changes in requirements in the data submission guide, the data supplier shall submit initial test files. This deadline may be extended by the lead organization when it determines that

additional time will be needed in order for the change to be implemented.

(3) **Submission file.** Data and claim files shall be submitted to the WA-APCD on a quarterly basis. On or before April 30th, July 31st, October 31st and January 31st of each year, data and claim files shall be submitted for all nondenied adjudicated claims paid in the preceding three months.

(4) **Resubmission file.** Failure to conform to the requirements of this chapter or the data submission guide shall result in the rejection of the applicable data and claim files. The lead organization shall notify the data supplier when data and claim files are rejected. All rejected files must be resubmitted in the appropriate, corrected format within fifteen business days of notification unless a written request for an extension is received by the lead organization before the expiration of this fifteen business day period.

(5) **Claims run-out file.** If health care coverage is terminated for a Washington covered person, the data supplier shall submit data for a six month period following the health care coverage termination date.

(6) **Replacement file.**

(a) A data supplier may replace a complete data file, claim file or both data and claim file submission. Requests must be made to the lead organization with a detailed explanation as to why the replacement is needed. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(b) The office shall approve or deny the request and provide written notification to the requestor within thirty calendar days of receipt of the request. The office decision on the request for a replacement file will be provided in writing. If the office does not approve the complete request for a replacement file, the written notification will include the reason for the denial or approval of the shorter period of time.

(c) Requests may not be made more than one year after the end of the month in which the file was submitted unless the data supplier can establish exceptional circumstances for the replacement. The lead organization may recommend approval and the office may approve a request for more than one year for exceptional circumstances. The office shall approve or deny the request using the process set forth in (b) of this subsection.

NEW SECTION

WAC 82-75-060 Historical data submission. (1) The purpose of collecting historical data into the WA-APCD is to permit the systematic analysis of the health care delivery system including evaluation of the effectiveness of the Patient Protection and Affordable Care Act signed into law on March 23, 2010.

(2) The lead organization will provide written notification to the data suppliers when the WA-APCD is ready to accept the submission of historical data. Data suppliers shall submit the historical data within sixty days of notification. Requests for an extension of time to submit historical data shall be made in accordance with WAC 82-75-080(3).

(3) "Historical data" means covered medical services claim files, pharmacy claim files, dental claim files, member eligibility and enrollment data files, and provider data files with necessary identifiers for the period January 1, 2011, through December 31, 2015.

(4) The office may grant an exception to this section and approve the filing of historical data for a period less than the period specified in subsection (3) of this section. In no event will an exception be granted for a period beginning later than January 1, 2013. Requests for an exception under this subsection shall be made to the lead organization within fifteen calendar days of being notified in accordance with subsection (2) of this section. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The office may approve the request for good cause.

NEW SECTION

WAC 82-75-070 Data submission guide. (1) Data files and claim files shall be submitted to the WA-APCD in accordance with the requirements set forth in this chapter and the data submission guide.

(2) The lead organization shall develop the data submission guide with input from stakeholders. The lead organization shall develop a process to allow for stakeholder review and comment on drafts of the data submission guide and all subsequent changes to the guide. The office shall have final approval authority over the data submission guide and all subsequent changes.

(3) The lead organization shall notify data suppliers before changes to the data submission guide are final. Notification shall occur no less than one hundred twenty calendar days prior to the effective date of any change.

(4) Upon good cause shown, data suppliers may be granted an extension to comply with any changes to the data submission guide. Requests for extensions or exceptions shall be made in accordance with WAC 82-75-080.

NEW SECTION

WAC 82-75-080 Waivers and extensions. (1) The office may grant a waiver of reporting requirements or an extension of time to a reporting requirement deadline based on extenuating circumstances.

(2) **Waivers.**

(a) A data supplier may request a waiver from submission for a period of time due to extenuating circumstances affecting the data supplier's ability to comply with the reporting requirement for that period.

(b) The request shall be for no more than one reporting year and shall contain a detailed explanation as to the reason the data supplier is unable to meet the reporting requirements.

(c) A request for a waiver must be submitted to the lead organization at least sixty calendar days prior to the applicable reporting deadline. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(d) The office may approve a request for extenuating circumstances. Approval may be for a time period shorter than

requested. The office shall approve or deny the request and provide written notification to the requester within thirty calendar days of receipt of the request. The office decision on the request for a waiver will be provided in writing. If the office does not approve a request for a waiver, the written notification will include the reason for the denial.

(3) **Extensions.**

(a) A data supplier may request an extension of time for submitting a quarterly report or the resubmission of a report due to extenuating circumstances affecting the data supplier's ability to submit the data by the deadline.

(b) The request shall be for no more than one reporting quarter and shall contain a detailed explanation as to the reason the data supplier is unable to meet the reporting requirements for that quarter.

(c) A request for an extension must be submitted to the lead organization at least thirty calendar days prior to the applicable reporting deadline unless the requestor is unable to meet this deadline due to circumstances beyond the data supplier's control. If unable to meet this deadline, the data supplier shall notify the lead organization in writing as soon as the data supplier determines that an extension is necessary.

(d) The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(e) The office may approve a request for extenuating circumstances. The office shall approve or deny the request and provide written notification to the requestor within fifteen calendar days from when the lead organization receives the request from the data supplier. The office decision on the request for an extension will be provided in writing. If the office does not approve a request for an extension, the written notification will include the reason for the denial.

NEW SECTION

WAC 82-75-090 Penalties for failure to comply with reporting requirements. (1) The office may assess fines for failure to comply with the requirements of this chapter including, but not limited to:

(a) General reporting requirements.

(b) Health care claim files and data files requirements.

(c) Health care claim files and data files submission requirements.

The office will not assess fines when the data supplier is working in good faith with the lead organization to comply with the reporting requirements.

(2) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with general reporting requirements including, but not limited to, the following occurrences:

(a) Failure to submit health care claim files or data files for a required line of business; and

(b) Submitting health information for an excluded line of business.

(3) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with health care claim file or data file requirements including, but not limited to, the following occurrences:

(a) Submitting a health care claim or data file in an unapproved layout;

(b) Submitting a data element in an unapproved format;

(c) Submitting a data element with unapproved coding; and

(d) Failure to submit a required data element.

(4) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with health care claim file or data file submission requirements including, but not limited to, the following occurrences:

(a) Failure to comply with WAC 82-75-050 (Data submission schedule);

(b) Rejection of a health care claim or data file by the data vendor that is not corrected by the data supplier; and

(c) Transmitting health care claim or data files using an unapproved process.

(5) Upon the failure to comply with a reporting requirement in this chapter, the office shall first issue a warning notice to a data supplier. The warning notice shall set forth the nature of the failure to comply and offer to provide assistance to the data supplier to correct the failure.

(6) A data supplier that fails to comply with the same reporting requirement in this chapter for which it previously received a warning notice, may be assessed a penalty of two hundred fifty dollars per day, not to exceed a maximum of twenty-five thousand dollars per occurrence. Each failure to comply with a reporting requirement for a reporting period is considered a separate occurrence.

(7) For good cause shown, the office may suspend in whole or in part any fine assessed in accordance with this section.

NEW SECTION

WAC 82-75-100 Administrative review. (1) Data suppliers may request an administrative review of an office decision to deny a request for an extension or waiver, or an assessment of a fine.

(2) A request for an administrative review may be initiated by a written petition filed with the office within thirty calendar days after notice of the denial or assessment of a fine. The petition shall include the following information:

(a) Data supplier's name, address, telephone number, e-mail address and contact person.

(b) Information about the subject of the appeal including remedy requested.

(c) A detailed explanation as to the issue or area of dispute, and why the dispute should be decided in the data supplier's favor.

(3) The petition and all materials submitted will be reviewed by the director or director's designee. The reviewing official may request additional information or a conference with the data supplier. A decision from the reviewing official shall be provided in writing to the data supplier no later than thirty calendar days after receipt of the petition. A denial of the petition will include the reasons for the denial.

NEW SECTION

WAC 82-75-110 Appeals. (1) A data supplier may request an appeal of a denial of its administrative review conducted in accordance with WAC 82-75-100.

(2) Request for an appeal must be submitted in writing to the office within fifteen calendar days after receipt of written notification of denial of its administrative review.

(3) Within ten business days of receipt of a written notice of appeal, the office will transmit the request to the office of administrative hearings (OAH).

(a) **Scheduling.** OAH will assign an administrative law judge (ALJ) to handle the appeal. The ALJ will notify parties of the time when any additional documents or arguments must be submitted. If a party fails to comply with a scheduling letter or established timelines, the ALJ may decline to consider arguments or documents submitted after the scheduled timelines. A status conference in complex cases may be scheduled to provide for the orderly resolution of the case and to narrow issues and arguments for hearing.

(b) **Hearings.** Hearings may be by telephone or in-person. The ALJ may decide the case without a hearing if legal or factual issues are not in dispute, the appellant does not request a hearing, or the appellant fails to appear at a scheduled hearing or otherwise fails to respond to inquiries. The ALJ will notify the appellant by mail whether a hearing will be held, whether the hearing will be in-person or by telephone, the location of any in-person hearing, and the date and time for any hearing in the case. The date and time for a hearing may be continued at the ALJ's discretion. Other office employees may attend a hearing, and the ALJ will notify the appellant when other office employees are attending. The appellant may appear in person or may be represented by an attorney.

(c) **Decisions.** The decision of the ALJ shall be considered a final decision. Either party or both may file a petition for review of the final decision to superior court. If neither party files an appeal within the time period set by RCW 34.05.542, the decision is conclusive and binding on all parties. The appeal must be filed within thirty days from service of the final decision.

WSR 15-22-104
PROPOSED RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed November 4, 2015, 10:02 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-18-014.

Title of Rule and Other Identifying Information: WAC 182-531-0050 Physician-related services definitions and new WAC 182-531-2020 Enhanced reimbursement—Long acting reversible contraception (LARC).

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 December 8, 2015, at 10:00 a.m.

Date of Intended Adoption: Not sooner than December 9, 2015.

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 December 8, 2015.

Assistance for Persons with Disabilities: Contact Amber Lougheed by December 4, 2015, e-mail amber.lougheed@hca.wa.gov, (360) 725-1349, TTY (800) 848-5429 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is creating WAC 182-531-2020 to allow for an enhanced payment for physician services associated with implanting or insertion of LARC. In addition, the agency is defining LARC in WAC 182-531-0050.

Reasons Supporting Proposal: See Purpose above.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

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

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Sean Sullivan, P.O. Box 42716, Olympia, WA 98504-2716, (360) 725-1344; Implementation and Enforcement: Myra Davis, P.O. Box 45510, Olympia, WA 98504-5510, (360) 725-1847.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The agency has determined that the proposed filing does not impose a disproportionate cost impact on small businesses or nonprofits.

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.

November 4, 2015
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-16-061, filed 7/30/12, effective 11/1/12)

WAC 182-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, apply to this chapter.

"Acquisition cost" - The cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" - Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" - A comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and

occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 182-550-2501).

"Add-on procedure(s)" - Secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" - The medical condition responsible for a hospital admission, as defined by ((~~ICD-9-M~~)) the ICD diagnostic code.

"Advanced registered nurse practitioner (ARNP)" - A registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and disability services administration (ADSA)" - The administration that administers directly or contracts for long-term care services((~~,~~)) including, but not limited to, nursing facility care and home and community services. See WAC 388-71-0202.

"Allowed charges" - The maximum amount reimbursed for any procedure that is allowed by the agency.

"Anesthesia technical advisory group (ATAG)" - An advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" - Any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" - A number of anesthesia units assigned to a surgical procedure that includes the usual ((~~pre-operative, intra-operative, and post-operative~~)) preoperative, intraoperative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" - Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" - Supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)," see WAC 182-500-0015.

"Call" - A face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" - A reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Center of excellence (COE)" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)," see WAC 182-500-0020.

"Certified registered nurse anesthetist (CRNA)" - An advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the national certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 182-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" - Regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" - Dollar amounts the agency uses to calculate the maximum allowable fee for physician-related services.

"Covered service" - A service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" - Physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" - 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).

((~~**"Diagnosis code"** - A set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.~~))

"Emergency medical condition(s)," see WAC 182-500-0030.

"Emergency services" - Medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" - The agency's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" - Procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" - The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the agency which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" - A term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 182-531-0550. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body, if such approval is required.

"Federally approved hemophilia treatment center" - A hemophilia treatment center (HTC) which:

(1) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

(2) Is qualified to participate in 340B discount purchasing as an HTC;

(3) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC web site;

(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and

(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

"Fee-for-service," see WAC 182-500-0035.

"Flat fee" - The maximum allowable fee established by the agency for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" - As defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 182-531-1700.

"HCPCS Level II" - Health care common procedure coding system, a coding system established by Centers for Medicare and Medicaid Services (CMS) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" - The name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" - A group of health care providers involved in the care of a client.

"Hospice" - A medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"((~~ICD-9-CM~~)) ICD," see "International Classification of Diseases((~~, 9th Revision, Clinical Modification~~))."

"Informed consent" - That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and

(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" - An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases((~~, 9th Revision, Clinical Modification (ICD-9-CM)~~)) (ICD)" - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumerical designations (coding).

"Investigational" - A term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" - Mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension," see WAC 182-501-0169.

"Long-acting reversible contraceptive (LARC)" - Subdermal implants and intrauterine devices (IUDs).

"Maximum allowable fee" - The maximum dollar amount that the agency will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 182-500-0070.

"Medicare physician fee schedule data base (MPFSDB)" - The official CMS publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" - The official CMS publication of the medicare fees for physician services.

"Medicare clinical diagnostic laboratory fee schedule" - The fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" - A client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or

code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient," see WAC 182-500-0080.

"Peer-reviewed medical literature" - Medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" - A written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" - Physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "current procedural terminology (CPT)."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" - The diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the agency's fee schedules that is not routinely covered.

"Preventive" - Medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization," see WAC 182-500-0085.

"Professional component" - The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" - The probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" - Face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 182-500-0085.

"Radioallergosorbent test" or **"RAST"** - A blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RBRVS RVU" - A measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - Physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"Reimbursement" - Payment to a provider or other agency-approved entity who bills according to the provisions in WAC 182-502-0100.

"Reimbursement steering committee (RSC)" - An interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Relative value guide (RVG)" - A system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" - A unit which is based on the resources required to perform an individual service or intervention.

"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.

"RSC RVU" - A unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"RVU," see relative value unit.

"Stat laboratory charges" - Charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" - A tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by CMS to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" - An advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Technical component" - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

NEW SECTION

WAC 182-531-2020 Enhanced reimbursement—Long-acting reversible contraception (LARC). (1) Effective for dates of service on or after September 1, 2015, the medicaid agency pays enhanced rates for physician procedure codes directly related to insertion or implant of long-acting reversible contraceptives (LARC).

(2) The agency pays the enhanced rate as a set amount above the standard resource based relative value scale (RBRVS) rate calculation described in WAC 182-531-1850.

(3) The agency will pay the enhanced rate to all providers eligible to bill for these services.

WSR 15-22-105
PROPOSED RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket TR-151079—Filed November 4, 2015, 10:13 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 15-11-092.

Title of Rule and Other Identifying Information: This rule making proposes amending rules in chapter 480-62 WAC, Railroad companies—Operations.

Hearing Location(s): Commission's Hearing Room 206, Second Floor, Richard Hemstad Building, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504-7250, on January 6, 2016, at 1:30 p.m.

Date of Intended Adoption: January 6, 2016.

Submit Written Comments to: Washington Utilities and Transportation Commission, 1300 South Evergreen Park Drive S.W., P.O. Box 47250, Olympia, WA 98504-7250, e-mail records@utc.wa.gov, fax (360) 586-1150, by December 7, 2015. Please include "Docket TR-151079" in your comments.

Assistance for Persons with Disabilities: Contact Debbie Aguilar by December 23, 2015, TTY (360) 586-8203 or (360) 664-1132.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The Washington utilities and transportation commission (commission) regulates public safety issues of railroads operating with [within] Washington. ESHB 1449, chapter 274, Laws of 2015, adopts financial responsibility reporting requirements that railroads hauling crude oil must include in the annual reports they submit to the commission. This proposal updates railroad annual reporting requirements on financial responsibility and safety standards for private crossings and provides opportunities for first-class cities to opt-in the commission crossing safety program.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 80.01.040, 81.04.160, 81.24.010, 81.53.010, 81.53.240, and chapter 81.44 RCW.

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

Name of Proponent: Washington utilities and transportation commission, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Lewis, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1206; Implementation and Enforcement: Steven V. King, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1115.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules will not result in or impose more than minor costs. Because there will not be more than minor increases in costs resulting from the proposed rule changes, a small business economic impact statement is not required under RCW 19.85.030(1).

A cost-benefit analysis is not required under RCW 34.05.328. The commission is not an agency to which RCW 34.05.328 applies. The proposed rules are not significant legislative rules of the sort referenced in RCW 34.05.328(5).

November 4, 2015
Steven V. King
Executive Director and Secretary

AMENDATORY SECTION (Amending WSR 01-04-026, filed 1/30/01, effective 3/2/01)

WAC 480-62-130 Application of this chapter. The rules in this chapter apply within certain cities and to any railroad company subject to the jurisdiction of the commission under RCW 81.04.010 and chapters 81.04, 81.24, 81.28, 81.36, 81.40, 81.44, 81.48, 81.52, 81.53, 81.54, 81.60, and 81.61 RCW, as set forth below:

(1) To all Class I, II, and III railroad companies operating within the state of Washington, with the exceptions noted in subsections (2), (3), and (4) of this section.

(2) To and within first-class cities except for WAC 480-62-145, 480-62-150, ((~~480-62-155,~~)) and 480-62-225.

(3) To and within cities with a population of more than 400,000 except for WAC 480-62-145, 480-62-150, ((~~480-62-155,~~)) 480-62-225, 480-62-230, and 480-62-235.

(4) To logging and industrial railroads except for WAC 480-62-200, 480-62-205, 480-62-215, 480-62-240, 480-62-245, 480-62-250, 480-62-300, the portions of WAC 480-62-310 that do not involve grade crossing accidents, WAC 480-62-315 (2), (4) and (5), and WAC 480-62-325.

NEW SECTION

WAC 480-62-260 First-class cities opt-in. (1) Participation in the commission's rail safety program. RCW 81.53.240 allows a first-class city to request participation in the commission's crossing safety inspection program. For the purposes of this section, the commission's crossing safety inspection program shall mean the inspection of grade crossings to ensure proper design and maintenance, as set forth in WAC 480-62-225. For the purposes of this section participation in the crossing safety inspection program shall not include the crossing petition process outlined in RCW 81.53.030 and 81.53.060.

(2) Process for opt-in. A first-class city must notify the commission of its intent to opt-in to the commission's rail safety program at least sixty days prior to the effective date requested by the city. A first-class city's request to opt-in must be accompanied by documentation demonstrating that the city's governing body has approved the terms and conditions set forth in a memorandum of understanding between the city and the commission governing the commission's assumption of rail crossing safety inspection authority within the city limits. A first-class city's request to opt-in will become effective on the date requested by the city or the first day of the month following commission approval of the memorandum of understanding referenced in this section, whichever occurs later.

(3) Technical assistance to first-class cities. For first-class cities that opt-in to the commission's crossing safety inspection program, the commission will provide technical assistance on grade crossing safety, maintenance, and modifications as agreed between the city and the commission.

(4) Process to opt-out. First-class cities that opt-in to the commission's crossing safety inspection program may opt-

out of the program by submitting to the commission documentation that the city's governing body has approved the withdrawal of the city from the commission's crossing safety inspection program. A city's notice of withdrawal must be submitted to the commission at least ninety days prior to the date upon which the city intends to assume all rail crossing safety inspections within its jurisdiction.

NEW SECTION

WAC 480-62-270 Safety standards at private crossings. (1) For the purposes of this section, the term "private crossings" has the same meaning as in RCW 81.53.010(8).

(2) At every private crossing through which any amount of crude oil is transported, the railroad must ensure that the following are installed on each side of the crossing within one hundred twenty days after this rule becomes effective:

(a) A thirty-inch or larger R1-1 stop sign, defined as a standard R1-1 in the *Manual on Uniform Traffic Control Devices*;

(b) An emergency notification system (ENS) sign that:

(i) Displays the necessary information for the dispatching railroad to receive reports of unsafe conditions at the crossing including, at a minimum:

(A) The toll-free telephone number of the railroad company established to receive reports;

(B) An explanation of the purpose of the sign (e.g., "Report emergency or problem to __"); and

(C) The United States Department of Transportation (USDOT) National Crossing Inventory number assigned to that crossing.

(ii) Measures at least twelve inches wide by nine inches high;

(iii) Is retroreflective;

(iv) Has legible text (i.e., letters and numerals) with a minimum character height of one inch; and

(v) Has white text set on a blue background with a white border, except that the USDOT National Crossing Inventory number may be black text set on a white rectangular background.

(c) A rectangular sign, at least three hundred square inches (twenty thousand square centimeters) in size, with the legend "Private Crossing" and the crossbuck symbol.

(3) All signs must have retroreflective tape applied to the sign posts.

(4) If the commission finds, after investigation, that a restricted sight distance, unfavorable roadway or crossing configuration, or other hazard exists at a private crossing, the commission will notify the railroad and to the extent the commission has contact information, the landowner. The railroad must ensure that additional safety measures are installed at the crossing including, but not necessarily limited to, signs authorized in the *Manual on Uniform Traffic Control Devices*, within one hundred twenty days of receiving notification of the hazard from commission staff.

(5) At private crossings where crude oil is transported, the commission will conduct inspections giving priority to private crossings with a high frequency of oil trains, in industrial areas, and high population centers.

(6) Nothing in this section modifies existing agreements between the railroad company and the landowner governing liability or cost allocation at the private crossing.

AMENDATORY SECTION (Amending WSR 04-05-031, filed 2/11/04, effective 3/13/04)

WAC 480-62-300 Annual reports—Regulatory fees. (1) The surface transportation board annual report form R1 must be used by Class I railroad companies ((~~as~~)) in addition to the annual report form ((~~for submission to~~)) published by the commission. Class II and Class III railroad companies must use report forms periodically published by the commission.

(2) Any railroad company that transports crude oil in Washington must submit to the commission, in addition to its annual report, a statement that contains:

(a) All insurance carried by the railroad company that covers any losses resulting from a reasonable worst case spill.

(b) Coverage amounts, limitations, and other conditions of the insurance identified in (a) of this subsection.

(c) Average and largest crude oil train, as measured in barrels, operated in Washington by the railroad company in the previous calendar year.

(d) Information sufficient to demonstrate the railroad company's ability to pay the costs to clean up a reasonable worst case spill of oil as defined in (e) of this subsection including, but not necessarily limited to, insurance, reserve accounts, letters of credit, or other financial instruments or resources on which the company can rely to pay all such costs. For the purposes of this section, the railroad company must calculate the total cleanup costs for a reasonable worst case spill based on a minimum cost of sixteen thousand eight hundred dollars per barrel multiplied by the percentage of the largest train of crude oil described in (e) of this subsection.

(e) For the purposes of this section, a reasonable worst case spill for railroads shall mean the percent of the largest train load of crude oil, as measured in barrels, moved by that company in the previous calendar year, as described below:

$$[(\text{Maximum Operating Speed}/65)^2 = \text{Reasonable Worst Case Percent}]$$

(f) For the purposes of this section, maximum operating speed shall mean the top speed that the railroad company operates any train carrying crude oil in the state.

(3) Each year every railroad company is responsible for obtaining the proper report form from the commission. Reports must be completed for the preceding calendar year's operations. One copy of the completed annual report, along with the regulatory fee, must be submitted to the commission no later than May 1st of each year.

((~~(3)~~)) (4) **Regulatory fees.** The railroad company regulatory fee for Class I railroads and companies that haul crude oil is set by statute at ((~~one~~)) two and one-half percent of gross intrastate operating revenue. The regulatory fee for all other railroad companies shall be set at one and one-half percent of gross intrastate operating revenue.

(a) The maximum regulatory fee is assessed each year, unless the commission issues an order establishing the regulatory fee at an amount less than the statutory maximum.

(b) The minimum regulatory fee that a railroad company must pay is twenty dollars.

(c) The twenty dollar minimum regulatory fee is waived for any railroad company with less than one thousand three hundred dollars in gross intrastate operating revenue.

(d) The commission does not grant extensions for payment of regulatory fees.

(e) If a company does not pay its regulatory fee by May 1st, the commission will assess an automatic late fee of two percent of the amount due, plus one percent interest for each month the fee remains unpaid.

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